CLAIMS EXPERIENCE AND MARKET CONDITIONS FOR MEDICAL MALPRACTICE INSURANCE

A REPORT BY THE

MICHIGAN COMMISSIONER OF INSURANCE

INSURANCE BUREAU
DEPARTMENT OF LICENSING AND REGULATION

MAY 1989

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EXECUTIVE SUMMARY

BACKGROUND

Public Act 173 of 1986 requires the Commissioner of Insurance to publish a report every two years which accomplishes all of the following:

(a) Describes the condition of the medical malpractice insurance market in this state.

(b) Contains information regarding specific claims experience filed with the commissioner.

(c) Makes recommendations concerning the medical malpractice insurance market in this state.

This is the first report and it is divided into four parts: Part I is an overview of the malpractice situation in Michigan since the 1970's; Part II provides an overview of the medical malpractice insurance market; Part III reviews the medical malpractice claims experience; and Part IV contains recommendations.

DATA

Public Act 44 of 1975 as amended by Public Act 173 of 1986 requires that insurers, attorneys, self-insured hospitals and anyone, other than an insurer, who has assumed liability to pay a medical malpractice claim report specific information to the Insurance Bureau. This is done through the use of two reporting forms. The Initial Report of Court Action (Form A) requests information on the name of the defendant, their specialty and license number, date of the incident and the date filed in court, county and court identification number. The Closed Claim Report contains the type of resolution, injury, location, and severity of injury, dates of report and closure, indemnity and expense payments. The information captured on these reports is entered on the Insurance Bureau's computerized data base.

All data items were sorted by computer to eliminate duplicate reporting. Additionally, the closed claim reports were sorted by hand for further accuracy. Information on cases with a reported indemnity of over $1 million were sent to the insurers for verification.

The Insurance Bureau's data base for January, 1983 through June, 1988, together with information collected from the American Medical Association, Office of Health and Medical Affairs, Department of Management and Budget, and insurance company filings, serves as the basis for this report.

Findings

The review of the marketplace and the data submitted to the Bureau revealed that:

- The medical malpractice insurance market continues to be highly concentrated, with a few large writers dominating.
- Physicians have more options with regard to source of insurance coverage than ever before. This has resulted in a decline in the number of Michigan physicians insured by companies licensed to do business in Michigan.
- Recent malpractice insurance rate increases have been considerably lower than in past years.
- Claims-made policies are now widely available, but physicians can still purchase occurrence policies.
- The number of active physicians in Michigan has continued to rise despite the increased cost of medical malpractice insurance.
- The number of initial malpractice actions filed peaked in 1986 and have declined noticeably since that time.
- Almost two-thirds of all actions are filed in Wayne, Oakland and Macomb Counties; ten counties account for over 80 percent of all claims.
- Obstetricians have the highest number of claims filed of any specialty.
- Approximately 50 percent of malpractice cases take three to five years after the date of injury to resolve.
- An overwhelming majority of claims closed were settled by the parties.
- Both the amount of indemnity paid and allocated expenses incurred in Wayne, Oakland and Macomb Counties tracks closely with those counties' proportion of closed claims.
- The number of obstetrical claims as a percentage of all closed claims is 5 percent or less each year.
- Total indemnity paid each year for obstetrical claims is less than 10 percent of the total paid for all claims; the allocated expenses for obstetrical claims constitute 6 percent or less of the total for all claims closed each year.

Conclusions and Recommendations

Due to the problem of duplicate data and the complications of reconciling the duplicate information, the Insurance Bureau would recommend the elimination of the reporting requirements for sources other than insurers or self-insured entities.

However, the malpractice insurance market has more options available for coverage and appears stronger now than in recent years. Physicians can choose from a range of options with regard to sources of coverage and rates are flattening as insurers file smaller rate increases. Some hospitals have experienced rate decreases and it does not appear that malpractice costs will be a critical factor in the continued existence of small hospitals.

With regard to claims, the information reported to the Bureau does not indicate a specific problem or problems as the cause of a malpractice "crisis" and there is an overall trend of decreasing claim filings against all specialties. Based on these improvements in the marketplace, the Insurance Bureau makes no recommendations for changes in the marketplace at this time.

PART II

THE MEDICAL MALPRACTICE INSURANCE MARKETPLACE

The market for medical malpractice insurance is made up of all of the sources from which health care providers can obtain professional liability insurance. The participants changed dramatically in the first medical malpractice crisis of the mid-1970s, and some less obvious but equally significant shifts have occurred as a result of the hardening of the liability insurance market which took place in the mid-1980s.

Sources of Medical Malpractice Insurance

In the early 1970s, the three largest writers of physicians' malpractice insurance in Michigan were the Medical Protective Company, Pacific Indemnity and Shelby Mutual. The three largest writers of hospital malpractice insurance were Aetna Casualty and Surety, Pacific Indemnity and Continental Casualty. By 1976, the three largest providers of physicians' malpractice coverage were the Brown-McNeely Fund created by the state legislature to insure physicians who could not otherwise obtain coverage, the Medical Protective Company and Michigan Physicians Mutual Liability Company, a new Michigan domestic insurer formed by physicians. For hospitals, the three largest writers of medical malpractice insurance in 1976 were the Argonaut Insurance Companies, Michigan Hospital Association Mutual Insurance Company and Hartford Accident and Indemnity. Shelby Mutual had abandoned the Michigan medical malpractice market completely and other major insurers such as Aetna Casualty, Pacific Indemnity and the Continental group were in the process of withdrawing.

Exhibit 1 lists the ten largest writers of medical malpractice insurance in Michigan at three points in time: immediately following the mid-1970s crisis, then during the relatively calm period of the early 1980s and finally the most recent calendar year, which followed another contraction in the general liability insurance marketplace. The exhibit illustrates several points about the Michigan malpractice market. First, entry to and exit from a particular line of insurance is extremely easy, as evidenced by the change in the ranking and mix of insurers at each point shown. Second, the specialty line of medical malpractice insurance is highly concentrated in a few insurers, and becoming more so, as the market share accounted for by the top four firms has increased from 61 percent in 1977 to 70 percent in 1982 to 84 percent by 1987. Third, the amount of premium generated by medical malpractice insurance sold by companies licensed in Michigan has increased by 124 percent over the past ten years. Most of the increase has occurred in the past few years, with 1987 written premiums exceeding 1982 volume by 92 percent.

EXHIBIT 1

TEN LARGEST WRITERS OF MEDICAL MALPRACTICE INSURANCE
(in thousands of dollars)

1977		1982		1987	
Company Name	Direct Premium Written	Company Name	Direct Premium Written	Company Name	Direct Premium Written
Medical Protective	$12,799	MPMLC	$ 19,909	MPMLC	$ 71,246
Argonaut Mid-West	11,728	Medical Protective	14,324	PICOM*	45,464
MPMLC	11,524	MHAMIC	12,041	MHAMIC	22,220
Brown-McNeely Fund	11,237	PICOM*	9,967	Natl Union Fire	7,284
MHAMIC	10,937	Hartford Accident	2,639	St Paul	6,454
Hartford Accident	6,105	St Paul	1,904	Medical Protective	4,982
Argonaut Insurance	3,654	Argonaut Midwest	1,878	Transportation Ins	3,844
Pacific Indemnity	2,974	Argonaut Ins	1,651	St Paul Mercury	2,352
St Paul	2,412	St Paul Mercury	1,399	American Continental	1,640
Vigilant	1,258	Ins Co of N America	1,206	Chicago Ins	1,612
All others	3,182	All others	6,445	All others	7,148
TOTAL	$ 77,710	TOTAL	$ 73,363	TOTAL	$174,246

* Successor to the Brown-McNeely Fund

SOURCE: Insurance Bureau, Annual Statements Filed by Insurers

Although insurance in general is an industry characterized by great ease of entry and exit, the medical malpractice line has shown a great amount of stability among the largest writers during recent years. After the medical malpractice crisis of the mid-1970s, this line became written predominately by specialty insurers formed by health care providers to meet their needs for professional liability insurance. Michigan was no exception, and by 1987 provider-owned domestic insurers accounted for 80 percent of direct written premiums. The dominance of provider-owned insurers was a direct outgrowth of the abandonment of the medical malpractice insurance market by multi-line insurers in the mid-1970s. While multi-line insurers such as the St. Paul Group, the Fireman's Fund Group (Chicago Insurance Company) and the CNA Group (Transportation Insurance Company) have continued to provide medical malpractice insurance to ancillary health professionals such as nurses, therapists, psychologists, pharmacists and medical technicians, only the Continental group (Continental Insurance Company) has attempted to re-enter the market for physicians' medical malpractice insurance. Continental's program of rates and forms for physicians' malpractice insurance was filed with and approved by the Michigan Insurance Bureau in 1988, so data measuring its impact is not yet available.

In addition to Continental, another new entrant to the medical malpractice insurance market in late 1988 was Butterworth Insurance Exchange, a reciprocal insurer formed by Butterworth Hospital in Grand Rapids to insure physicians who are members of the hospital's medical staff. This company continues the predominant pattern of health care providers sponsoring their own captive insurance programs to meet their liability insurance needs.

One of the differences between the hardening of the liability insurance market which occurred in the mid-1970s and the one which occurred in the mid-1980s was that after the latter event, many physicians turned to mechanisms other than the health care provider-sponsored programs which had been created after the first crisis. A number of large hospitals established offshore captive insurers to insure themselves and physicians with admitting privileges at their hospitals against medical malpractice liability. As a result, the number of Michigan physicians insured by companies licensed to do business in Michigan has declined. Exhibit 2 reflects the growing volume of malpractice insurance premiums written by non-admitted insurers and their increasing share of the medical malpractice market. Another source of medical malpractice insurance for health professionals was created when Congress amended the Product Liability Risk Retention Act of 1981 to form the Risk Retention Act of 1986 which allowed the formation of risk retention groups and purchasing groups for all types of liability insurance. A risk retention group is a member-owned liability insurer licensed in at least one state which may then provide liability insurance to all of its members/policyholders without having to be licensed

EXHIBIT 2

MEDICAL MALPRACTICE INSURANCE PREMIUMS
WRITTEN BY NON-ADMITTED INSURERS
(in thousands of dollars)

Year	Premium*	% of Total Liability* Written by Non-Admitted Insurers	% of Total Medical** Malpractice Premiums
1982	5,465	9.8	5.7
1983	N/A	N/A	N/A
1984	13,124	20.5	11.6
1985	30,676	18.8	17.5
1986	48,431	20.3	20.2
1987	70,128	27.1	28.7
1988	72,353	27.7	NA

SOURCE:
*Insurance Bureau Semiannual Surplus Lines Statements
**Insurance Bureau Property & Liability By-Line Statistical Report

in each state where its members are located. A purchasing group is a group which purchases liability insurance on a group basis for its members in order to cover their similar or related liability exposure. The members of either a risk retention group or a purchasing group must be engaged in similar businesses or activities or exposed to similar liability by virtue of their trade, product, service, premises or operation.

Since the Risk Retention Act was passed, more than 50 risk retention groups and about 300 purchasing groups have been formed nationally. The most common purpose for the formation of purchasing groups has been to obtain professional liability insurance, most frequently medical malpractice insurance. Seven risk retention groups and thirty-two purchasing groups have filed information with the Insurance Bureau indicating their intent to provide medical malpractice insurance to their members in Michigan. A list of these risk retention groups and purchasing groups is included in Appendix B.

Public Act 173 of 1986 also provided for the creation of limited liability pools. Authorized by Chapter 65 of the Insurance Code, these pools may be used to issue liability policies for commercial, industrial or professional liability. Before a limited liability pool can be formed, the Commissioner of

Insurance must hold a public hearing and make a determination that the type of liability insurance to be offered by the pool is not readily available or not available at a reasonable premium for that type of coverage or class of risk.

In March, 1988, a committee of physicians requested a hearing to determine whether malpractice insurance was available or was not available at a reasonable premium in the western region of Michigan, including the Upper Peninsula. Following a public hearing and testimony from a consulting actuary, the Commissioner determined that a limited liability pool could not be formed to insure physicians in western Michigan because coverage was available at a reasonable premium.

The creation of domestic doctor and hospital-owned insurers, the re-entry of the market by a few foreign (non-Michigan domiciled) insurers, the formation of risk retention groups and the proliferation of offshore captives have resulted in more availability of medical malpractice insurance now than has existed for many years. However, this availability has some limitations. Most of the insurers domiciled in Michigan do not offer coverage limits in excess of $200,000 per occurrence/$600,000 aggregate. Those licensed insurers offering higher limits will do so only on a claims-made basis, even though lower limits are available on an occurrence basis. Risk retention groups and offshore captives may offer higher limits of coverage, but policyholders of these insurers are not protected by the Michigan Property and Casualty Guaranty Fund in the event of the insurers' insolvency. So even though basic coverage is widely available from a variety of sources, some physicians may still feel they are not able to find the amount of coverage they need under the terms they desire. Furthermore, some sources of malpractice insurance are only open to particular providers, such as those with admitting privileges at certain hospitals or certain types of specialists.

Pricing of Medical Malpractice Insurance for Physicians

The data on market structure for medical malpractice insurance in Michigan suggests an oligopolistic market -- a market dominated by a few firms, each of whom would tend to quickly lose market share if they raised their prices above the market price and would quickly gain market share at a lower price. The effect of this market structure is to keep insurers' rate levels very close together. Exhibits 3, 4, 5 and 6 show the base rates charged by the three largest writers of physicians' insurance coverage -- Michigan Physicians Mutual Liability Company, Physicians Insurance Company of Michigan and Medical Protective -- plus a newcomer, Butterworth Insurance Exchange. A description of the specialty areas included in each class may be found in Appendix D. The rates filed by Continental Insurance Company are not on a basis comparable to the rates in these exhibits.

EXHIBIT 3

MICHIGAN PHYSICIANS MUTUAL LIABILITY COMPANY

Base Rates Charged for $100,000/$300,000 Limits, Occurrence Form

Class	Territory 1*	Territory 2**	Territory 3
I	$ 6,704	$ 4,013	$ 3,648
IB	8,033	4,825	4,386
II	9,238	5,551	5,047
III	14,985	9,004	8,185
IV	25,585	15,317	13,925
IVB	26,718	16,064	14,604
V	34,823	20,847	18,952
VB	36,364	21,864	19,877
VIA	46,965	28,117	25,561
VI	58,706	35,146	31,951
VII	68,705	41,131	37,392
VIII	74,952	44,871	40,792
VIIIB	79,594	47,804	43,458
IX	87,553	52,532	47,756

* Territory 1 includes Wayne, Oakland and Macomb counties.

** Territory 2 includes Bay, Genesee, Hillsdale, Huron, Ingham, Jackson, Lapeer, Lenawee, Livingston, Monroe, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola and Washtenaw counties.

EXHIBIT 4

PHYSICIANS INSURANCE COMPANY OF MICHIGAN

Base Rates Charged for $100,000/$300,000 Limits, Occurrence Form

Class	Territory I*		Territory II
	M.D.	D.O.	
1	$ 6,601	$ 7,921	
2	9,044	11,756	Territory II rates are determined by applying a factor of .60 to Territory I rates.
2A	10,232	13,301	
3	14,522	18,878	
4	25,084	37,626	
5	27,724	41,586	
6	34,985	52,478	
8	58,749	88,123	
8A	64,690	97,035	

* Territory I includes Wayne, Oakland and Macomb counties.

EXHIBIT 5

MEDICAL PROTECTIVE COMPANY

Base Rates Charged for $100,000/$300,000 Limits, Occurrence Form

Class	Area 1*	Area 2
1	$ 7,953	$ 4,881
2	15,111	9,274
3	19,883	12,203
4	23,859	14,643
5	46,127	28,310
6	54,876	33,679
7	63,624	39,048
8	71,577	43,929

* Area 1 includes Wayne, Oakland, Macomb and Genesee counties.

EXHIBIT 6

BUTTERWORTH INSURANCE EXCHANGE

Base Rates Charged for $100,000/$300,000 Limits, Occurrence Form

Class	Territory 1*	Territory 2
I	$ 5,933	$ 3,559
IB	7,223	4,334
II	8,033	4,820
IIB	9,735	5,841
IIIA	11,208	6,725
III	13,030	7,818
IVA	17,997	10,798
IV	22,642	13,585
IVB	23,870	14,322
V	30,817	18,490
VB	33,292	19,975
VI	51,952	31,172
VIIA	55,908	33,545
VII	60,801	36,480
VIII	66,329	39,797
IX	79,594	47,756

* Territory 1 includes Wayne, Oakland and Macomb counties.

Virtually all of the insurers filing rates for physicians' medical malpractice insurance have combined Wayne, Oakland and Macomb counties into one rating territory. Medical Protective Company has included Genesee County in this group as well. The rates for the remainder of the state are approximately 60 percent of the rate charged for the same class in the higher territory. Michigan Physicians Mutual Liability Company has further divided the remainder of the state into two territories, one at 60 percent of the highest territory rates and another encompassing western Michigan and the Upper Peninsula at approximately 54.5 percent of the highest rate. Territorial rating is not new in medical malpractice insurance. Medical Protective and Shelby Mutual were using two territories for a number of years prior to the crisis of the mid-1970s.

Another rating factor which has changed over the years has been the classification of physicians into risk groups. Twenty-five years ago, there were only four classifications for physicians. In an attempt to further identify and separate out the better risk specialties within each classification, insurers have subdivided these groups. While the highest and lowest rates charged by each company do not vary greatly, there is considerable variance within that range between insurers. Medical Protective uses the least number of classifications at eight, while Butterworth Insurance Exchange has the most with sixteen. The class plans usually assign family practitioners, general practitioners and specialists in internal medicine with no surgery to class 2. Highest rated specialties are generally cardiovascular and thoracic surgery, obstetrical surgery, orthopedic surgery and neurosurgery. One of the highest rated specialties in the mid-1970s, anesthesiology, has experienced a relative decrease in risk and is now in the mid-range of classifications.

A factor in rating which has not changed over the years is whether the physician is an allopathic physician (M.D.) or osteopathic physician (D.O.). All of the filed rates for medical malpractice insurers in Michigan show a higher rate for D.O.s than M.D.s. In some cases, such as Physicians Insurance Company of Michigan, the insurer uses a separate rate schedule for M.D.s and D.O.s. In other cases, the insurer assigns D.O.s to a higher rate classification than an M.D. in the same specialty. Loss data filed by the insurers writing medical malpractice insurance has supported this differential, although there is no clear explanation for the difference in experience.

Physicians' medical malpractice insurance rates have been increasing rapidly for a long time. In the roughly five year period between June 1966 and October 1971, the rates recommended by the Insurance Services Office for physicians' medical malpractice coverage for limits of $100,000/$300,000 increased by 275 percent for physicians in the lowest rated classification and 562 percent for specialties in the highest rated class. By 1976, five years later, the lowest rated physicians' rates had

increased from $458 charged by Pacific Indemnity for $100,000/$300,000 limits to $1,100 or $1,500 charged by Michigan Physicians Mutual Liability Company, depending on territory. Exhibit 7 shows a rate history for the three largest writers of physicians' insurance, from the inception of MPMLC in 1976 and PICOM in 1980 to the present time.

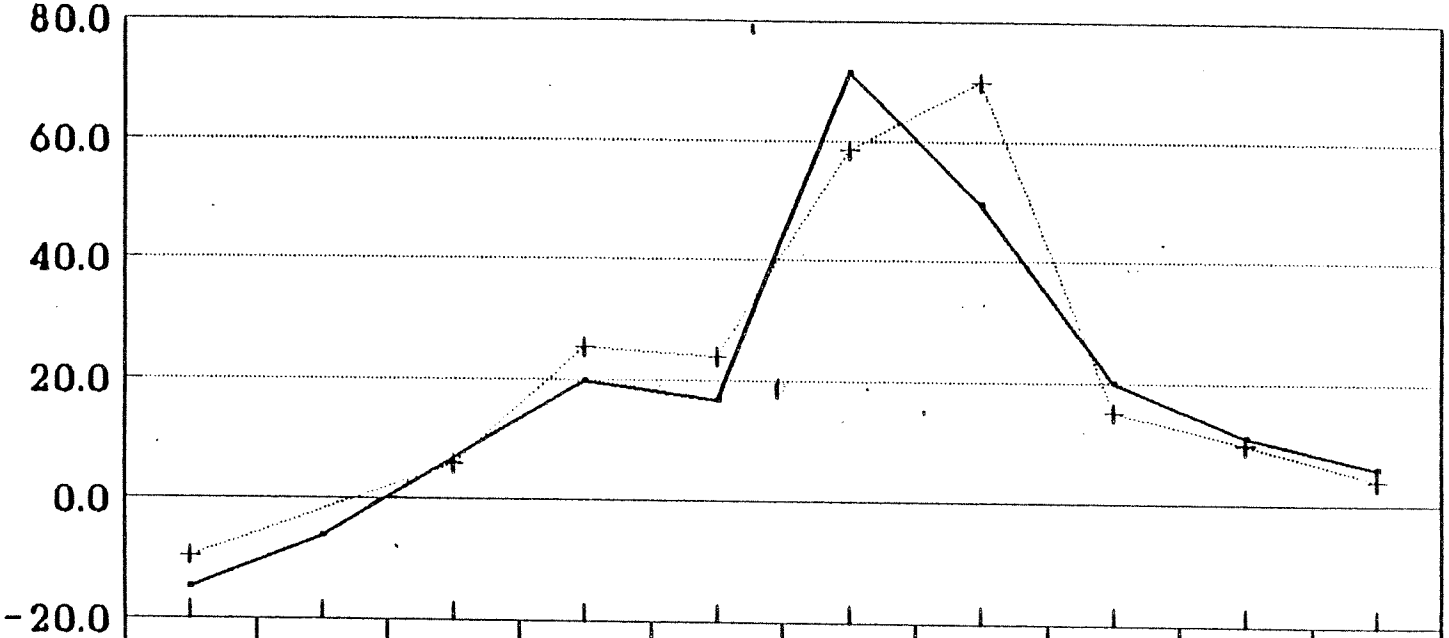
EXHIBIT 7

PHYSICIANS' MEDICAL MALPRACTICE RATE HISTORY FOR THREE LARGEST INSURERS

	Percent Change		
Effective Date	MPMLC	PICOM	Medical Protective
1- 8-78	- 2.2		
7- 1-79	- 5.0		
7- 1-80		-25.3	
10- 1-80		10.3	
11- 1-81	- 9.7		
4- 1-81		- 6.2	
7- 1-82	6.0		
4- 1-83	25.4	19.8	
6- 1-83			30.0
5- 1-84			44.2
5-15-84		16.8	
6- 1-84	23.8		
3- 1-85		48.0	
4- 1-85	58.4		
7- 1-85			55.0
12-15-85		23.7	
2- 1-86	70.0		
3-31-86		49.3	
7- 1-86			51.6
10- 1-86	1.0		
4- 1-87	15.0		
6- 1-87		20.0	
6- 1-88	9.8		
6-15-88		11.0	

A graph of MPMLC's and PICOM's rate history illustrates more clearly how their rates have stayed close together. As a market with a small number of sellers, medical malpractice insurers are aware that if they raise their prices too far above their competitors' levels, they will lose market share. The large increases filed in 1985 were done at the insistence of the Insurance Bureau, which was concerned about loss development trends and the adequacy of the malpractice insurers' reserves. Another large increase to bring rates and reserves to more adequate levels was taken by the insurers in 1986. Since that time, rate increases have been considerably more moderate. One insurer, Medical Protective Company, has not filed for a rate change since 1986. However, the company has been steadily

RATE FILING HISTORY
MD'S AND DO'S ONLY



	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
PICOM	-15.0	-6.2		19.8	16.8	71.7	49.3	20.0	11.0	6.2
MPMLC	-9.7		6.0	25.4	23.8	58.4	70.0	15.0	9.9	4.1

PICOM MPMLC

5/23/89

SOURCE: Physicians Insurance Compan[illegible]f Michigan

BUTTERWORTH INSURANCE EXCHANGE
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

VIII. CLASSIFICATIONS

A. Class I

No surgery

D.O.s	M.D.'s	
7x230	8x230	Aerospace Medicine
7x254	8x254	Allergy
7x256	8x256	Dermatology
7x240	8x240	Forensic or Legal Medicine
	8x243	Geriatrics
7x245	8x245	Hematology - no chemotherapy, no biopsy
7x232	8x232	Hypnosis
7x248	8x248	Nutrition
7x266	8x266	Pathology
7x234	8x234	Pharmacology - clinical
7x235	8x235	Physical Medicine, Physiatry, Manipulative Therapy or Rehabilitaton, (or not otherwise classified)
7x231	8x231	Preventative Medicine
*	8x249	Psychiatry - no supervision, direction or performance of shock therapy
7x250	8x250	Psychosomatic Medicine
7x236	8x236	Public Health

* B. Class IB

No surgery

D.O.s	M.D.'s	
*	8x739	Family Practice
* 7x243		Geratrics
* 7x249		Psychiatry - no supervision, direction or performance of shock therapy

C. Class II

No Surgery

M.D.'s	
8x237	Diabetes
8x238	Endocrinology
8x241	Gastroenterology
8x242	General Practice
8x244	Gynecology
8x246	Infectious Diseases
8x257	Internal Medicine
8x258	Laryngology
8x259	Neoplastic Disease
8x260	Nephrology

BUTTERWORTH INSURANCE EXCHANGE
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

C. Class II (Continued)

No Surgery

M.D.'s	
8x261	Neurology - no supervision, direction, or performance of angiography, myelography or pneumoencephalography
8x262	Nuclear Medicine
8x233	Occupational Medicine
8x114	Ophthalmology - including surgery
8x263	Opthalmology - no surgery
8x264	Otology
8x265	Otorhinolaryngology
8x268	Physicians - not otherwise classified
8x269	Pulmonary Disease
8x253	Radiology - diagnostic
8x280	Radiology - including therapeutic
8x252	Rheumatology
8X247	Rhinology

* D. Class IIB

M.D.'s	
8x267	Pediatrics - no surgery

* E. Class IIIA

No Surgery

D.O.'s	
7x238	Endocrinology
7x239	Family Practice
7x241	Gastroenterology
7x242	General Practice
7x244	Gynecology
7x257	Internal medicine
7x258	Laryngology
7x262	Nuclear Medicine
7x233	Occupational Medicine
7x263	Ophthalmology - no surgery
7x264	Otology
7x265	Otorhinolaryngology
7x268	Physicians - not otherwise classified
7x269	Pulmonary Disease
7x253	Radiology - diagnostic
7x252	Rheumatology
7x247	Rhinology

BUTTERWORTH INSURANCE EXCHANGE
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

F. Class III

No Surgery

D.O.'s

7x237	Diabetes
7x246	Infectious Diseases
7x259	Neoplastic Disease
7x260	Nephrology
7x261	Neurology - No supervision, direction, or performance of angiography, myelography or pneumoencephalography
7x114	Opthalmology - including surgery
7x267	Pediatrics - no surgery
7x280	Radiology - including therapeutic

M.D.'s

8x101	Bronchoesophagology
8x281	Cardiovascular Diseases - minor surgery
8x271	Diabetes - minor surgery
8x272	Endocrinology - minor surgery
8x273	Family Practice - minor surgery
8x274	Gastroenterology - minor surgery
8x275	General Practice - minor surgery
8x276	Geriatrics - minor surgery
8x277	Gynecology - minor surgery
8x278	Hematology - minor surgery
8x279	Infectious Diseases - minor surgery
8x283	Intensive Care Medicine
8x284	Internal Medicine - minor surgery
8x285	Laryngology - minor surgery
8x286	Neoplastic Diseases - minor surgery
8x287	Nephrology - minor surgery
8x288	Neurology - minor surgery - including shock therapy, angiography
8x290	Otology - minor surgery
8x291	Otorhinolaryngology - minor surgery
8x292	Pathology - minor surgery
8x293	Pediatrics - minor surgery
8x294	Physicians - minor surgery - not otherwise classified
8x270	Rhinology - minor surgery
8x115	Surgery - colon and rectal (Proctology)

G. Class IVA

D.O.'s

7x281	Cardiovascular Diseases - minor surgery
7x272	Endocrinology - minor surgery
7x273	Family Practice - minor surgery
7x274	Gastroenterology - minor surgery

G. Class IVA (Continued)

D.O.'s

7x275 General Practice - minor surgery
7x276 Geriatrics - minor surgery
7x277 Gynecology - minor surgery
7x278 Hematology - minor surgery
7x283 Intensive Care Medicine
7x284 Internal Medicine - minor surgery
7x285 Laryngology - minor surgery
7x288 Neurology - minor surgery - including shock therapy, angiography
7x290 Otology - minor surgery
7x291 Otorhinolaryngology - minor surgery
7x292 Pathology - minor surgery
7x293 Pediatrics - minor surgery
7x294 Physicians - minor surgery - not otherwise classified
7x270 Rhinology - minor surgery

H. Class IV

D.O.'s

7x101 Bronchoesophagology
7x271 Diabetes - minor surgery
7x279 Infectious Diseases - minor surgery
7x286 Neoplastic Diseases - minor surgery
7x287 Nephrology -minor surgery
7x115 Surgery - colon and rectal (Proctology)

M.D.'s

8x151 Anesthesiology
8x102 Emergency Medicine - no major surgery
8x117 Surgery - general practice or family practice - not primarily engaged in major surgery -not otherwise classified
8x145 Surgery - urological

I. Class IVB

M.D.'s

8x103 Surgery - endocrinology
8x104 Surgery - gastroenterology
8x105 Surgery - geriatrics
8x170 Surgery - head and neck
8x106 Surgery - laryngology
8x107 Surgery - neoplastic
8x108 Surgery - nephrology
8x158 Surgery - otology
8x159 Surgery - otorhinolaryngology - no plastic surgery
8x160 Surgery - rhinology - no plastic surgery

J. Class V

D.O.'s	
7x151	Anesthesiology
7x102	Emergency Medicine - no major surgery
7x117	Surgery - general practice or family practice - not primarily engaged in major surgery - not otherwise classified
7x145	Surgery - urological

M.D.'s	
8x157	Emergency Medicine - including major surgery
8x166	Surgery-abdominal
8x143	Surgery - general - not otherwise classified
8x169	Surgery - hand
8x155	Surgery - otorhinolaryngology - plastic surgery
8x156	Surgery - plastic - not otherwise classified
8x171	Surgery - traumatic

* K. Class VB

M.D.'s	
* 8x141	Surgery - cardiac
* 8x167	Surgery - gynecology

L. Class VI

D.O.'s	
7x157	Emergency Medicine - including major surgery
* 7x143	Surgery - general - not otherwise classified
* 7x167	Surgery - gynecology
7x169	Surgery - hand
7x159	Surgery - otorhinolaryngology - no plastic surgery
7x155	Surgery - otorhinolaryngology- including plastic
7x156	Surgery - plastic - not otherwise classified

M.D.'s	
8x168	Surgery - obstetrics
8x153	Surgery - obstetrics and gynecology

* M. Class VIIA

M.D's	
* 8x150	Surgery - cardiovascular
* 8x154	Surgery - orthopedic
* 8x144	Surgery - thoracic
* 8x146	Surgery - vascular

N. Class VII

M.D.'s	
8x152	Surgery - neurological

BUTTERWORTH INSURANCE EXCHANGE
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

* O. Class VIII

(Reserved for future use.)

P. Class IX

D.O.'s	
7x168	Surgery - obstetrics
7x153	Surgery - obstetrics and gynecology
7x141	Surgery - cardiac
7x150	Surgery - cardiovascular
7x154	Surgery - orthopedic
7x144	Surgery - thoracic
7x146	Surgery - vascular
7x152	Surgery - neurological

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FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899

PHYSICIANS RATE CLASSES

CLASS I

INTERNS, RESIDENTS AND FELLOWS (MOONLIGHTING ONLY).

NON-SURGICAL SPECIALTIES, TO INCLUDE: ALLERGY, CARDIOVASCULAR DISEA DERMATOLOGY, GASTROENTEROLOGY, INTERNAL MEDICINE, NEUROLOGY, PATHOLOGY, PSYCIATRY, PULMONARY DISEASES, RADIOLOGY.

FAMILY PRACTICE, GENERAL PRACTICE (NO SURGERY).

SURGICAL SPECIALISTS DOING NO SURGERY.

PROCEDURES NOT COVERED ON THIS CLASS:
ACUPUNCTURE,

CARDIAC CATHETERIZATION (EXCEPT SWAN-GANZ),
RADIATION THERAPY,

RADIOPAQUE DYE INJECTION DIAGNOSTIC PROCEDURES,
SHOCK THERAPY,

CLASS II

PHYSICIANS, OTHERWISE IN CLASS I, PERFORMING RADIATION THERAPY, RADI PAQUE DYE INJECTION DIAGNOSTIC PROCEDURES, OR SHOCK THERAPY.

GENERAL PRACTICE OR SPECIALISTS PERFORMING MINOR SURGERY (NO DELIVEF OR ASSISTING IN MAJOR SURGERY ON THEIR OWN PATIENTS.

PEDIATRICS (NO SURGERY).

CLASS III

PHYSICIANS, OTHERWISE IN CLASS I OR CLASS II, PERFORMING ACUPUNCTURE OR CARDIAC CATHETERIZATION (NOT SWAN-GANZ).

GENERAL PRACTICE OR SPECIALISTS PERFORMING MAJOR SURGERY OR ASSISTI IN MAJOR SURGERY ON OTHER THAN THEIR OWN PATIENTS-NOT PRIMARILY ENGAGED IN MAJOR SURGERY (NO DELIVERIES).

SURGICAL SPECIALISTS IN OPHTHALMOLOGY, COLON AND RECTAL SURGERY.

EFFECTIVE 8-1-86

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PHYSICIANS RATE CLASSES (CONT'D)

CLASS IV

UROLOGY.
EMERGENCY MEDICINE.

GENERAL PRACTICE INCLUDING DELIVERIES.

CLASS V

SPECIALISTS IN ANESTHESIOLOGY, OR ANY PHYSICIAN ADMINISTERING GENERAL OR SPINAL ANESTHESIA, SADDLE BLOCKS, CAUDALS.

SURGICAL SPECIALISTS IN ABDOMINAL SURGERY, GENERAL SURGERY, OTO-RHINOLARYNGOLOGY.

CLASS VI

SURGICAL SPECIALISTS IN PLASTIC SURGERY.

CLASS VII

SURGICAL SPECIALISTS IN CARDIOVASCULAR SURGERY, ORTHOPEDIC SURGERY, THORACIC SURGERY, TRAUMATIC SURGERY, VASCULAR SURGERY.

CLASS VIII

SURGICAL SPECIALISTS IN NEUROLOGICAL SURGERY, OBSTETRICS AND/OR GYNECOLOGY.

EFFECTIVE 8-1-86

VIII. CLASSIFICATIONS

A. Class I

No Surgery

D.O.'s	M.D.'s	
7x230	8x230	Aerospace Medicine
7x254	8x254	Allergy
7x256	8x256	Dermatology
7x240	8x240	Forensic or Legal Medicine
7x245	8x245	Hematology - no chemotherapy, no biopsy
7x232	8x232	Hypnosis
7x248	8x248	Nutrition
7x266	8x266	Pathology
7x234	8x234	Pharmacology - clinical
7x235	8x235	Physical Medicine, Physiatry, Manipulative Therapy or Rehabilitation, (or not otherwise classified)
7x231	8x231	Preventive Medicine
7x250	8x250	Psychosomatic Medicine
7x236	8x236	Public Health

B. Class IB

D.O.'s	M.D.'s	
	8x239	Family Practice
7x249	8x249	Psychiatry

C. Class II

No Surgery

M.D.'s	
8x237	Diabetes
8x238	Endocrinology
8x241	Gastroenterology
8x242	General Practice
8x243	Geriatrics
8x244	Gynecology
8x246	Infectious Diseases
8x257	Internal Medicine
8x258	Laryngology
8x259	Neoplastic Disease
8x260	Nephrology
8x261	Neurology -no supervision, direction, or performance of angiography, myelography or pneumoencephalography
8x262	Nuclear Medicine
8x233	Occupational Medicine
8x114	Ophthalmology - including surgery
8x263	Ophthalmology - no surgery
8x264	Otology
8x265	Otorhinolaryngology
8x268	Physicians - not otherwise classified
8x269	Pulmonary Disease
8x253	Radiology - diagnostic
8x280	Radiology - including therapeutic

8x252 Rheumatology
8x247 Rhinology

D. Class III

D.O.'s
7x237 Diabetes
7x238 Endocrinology
7x239 Family Practice
7x241 Gastroenterology
7x242 General Practice
7x243 Geriatrics
7x244 Gynecology
7x246 Infectious Diseases
7x257 Internal Medicine
7x258 Laryngology
7x259 Neoplastic Disease
7x260 Nephrology
7x261 Neurology - no supervision, direction, or performance of angiography, myelography or pneumoencephalography
7x262 Nuclear Medicine
7x233 Occupational Medicine
7x114 Ophthalmology - including surgery
7x263 Ophthalmology - no surgery
7x264 Otology
7x265 Otorhinolaryngology
7x268 Physicians - not otherwise classified
7x269 Pulmonary Disease
7x253 Radiology - diagnostic
7x280 Radiology - including therapeutic
7x252 Rheumatology
7x247 Rhinology

M.D.'s
8x101 Bronchoesophagology
8x281 Cardiovascular Diseases
8x271 Diabetes - minor surgery
8x272 Endocrinology - minor surgery
8x273 Family Practice - minor surgery
8x274 Gastroenterology - minor surgery
8x275 General Practice - minor surgery
8x276 Geriatrics - minor surgery
8x277 Gynecology - minor surgery
8x278 Hematology - minor surgery
8x279 Infectious Diseases - minor surgery
8x283 Intensive Care Medicine
8x284 Internal Medicine - minor surgery
8x285 Laryngology
8x286 Neoplastic Diseases - minor surgery
8x287 Nephrology - minor surgery
8x288 Neurology - minor surgery - shock therapy, angiography
8x290 Otology - minor surgery
8x291 Otorhinolaryngology - minor surgery
8x292 Pathology - minor surgery
8x267 Pediatrics
8x294 Physicians - not otherwise classifed
8x270 Rhinology - minor surgery

8x115 Surgery - colon and rectal (Proctology)

E. Class IV

D.O.'s
7x101 Bronchoesophagology
7x281 Cardiovascular Diseases
7x271 Diabetes - minor surgery
7x272 Endocrinology - minor surgery
7x273 Family Practice - minor surgery
7x274 Gastroenterology - minor surgery
7x275 General Practice - minor surgery
7x276 Geriatrics - minor surgery
7x277 Gynecology - minor surgery
7x278 Hematology - minor surgery
7x279 Infectious Diseases - minor surgery
7x283 Intensive Care Medicine
7x284 Internal Medicine - minor surgery
7x285 Laryngology
7x286 Neoplastic Diseases - minor surgery
7x287 Nephrology - minor surgery
7x288 Neurology - minor surgery - shock therapy, angiography
7x290 Otology - minor surgery
7x291 Otorhinolaryngology - minor surgery
7x292 Pathology - minor surgery
7x267 Pediatrics
7x294 Physicians - not otherwise classifed
7x270 Rhinology - minor surgery
7x115 Surgery - colon and rectal (Proctology)

M.D.'s
8x151 Anesthesiology
8x117 Surgery - general practice or family practice - not primarily engaged in major surgery - not otherwise classified
8x145 Surgery - urological

F. Class IVB

M.D.'s
8x102 Emergency Medicine - no major surgery

G. Class V

D.O.'s
7x151 Anesthesiology
7x117 Surgery - general practice or family practice - not primarily engaged in major surgery - not otherwise classified
7x145 Surgery - urological

M.D.'s
8x157 Emergency Medicine - including major surgery
8x166 Surgery - abdominal
8x103 Surgery - endocrinology
8x104 Surgery - gastroenterology
8x143 Surgery - general - not otherwise classified
8x105 Surgery - geriatrics
8x169 Surgery - hand

8x170 Surgery - head and neck
8x106 Surgery - laryngology
8x107 Surgery - neoplastic
8x108 Surgery - nephrology
8x158 Surgery - otology
8x159 Surgery - otorhinolaryngology - no plastic surgery
8x155 Surgery - otorhinolaryngology - plastic surgery
8x156 Surgery - plastic - not otherwise classified
8x160 Surgery - rhinology - not plastic surgery
8x171 Surgery - traumatic

H. Class VB

D.O.'s
7x102 Emergency Medicine - no major surgery

I. Class VIA

M.D.'s
8x167 Surgery - Gynecology

J. Class VI

D.O.'s
7x157 Emergency Medicine - including major surgery
7x169 Surgery - hand
7x159 Surgery - otorhinolaryngology - no plastic surgery
7x155 Surgery - otorhinolaryngology - including plastic
7x156 Surgery - plastic - not otherwise classified

M.D.'s
8x168 Surgery - obstetrics
8x153 Surgery - obstetrics and gynecology

K. Class VII

M.D.'s
8x141 Surgery - cardiac
8x150 Surgery - cardiovascular
8x154 Surgery - orthopedic
8x144 Surgery - thoracic
8x146 Surgery - vascular

L. Class VIII

D.O.'s
7x143 Surgery - general - not otherwise classified

M.D.'s
8x152 Surgery - neurological

M. Class VIIIB

D.O.'s
7x167 Surgery - Gynecology

N. Class IX

D.O.'s
7x168 Surgery - obstetrics
7x153 Surgery - obstetrics and gynecology
7x141 Surgery - cardiac
7x150 Surgery - cardiovascular
7x154 Surgery - orthopedic
7x144 Surgery - thoracic
7x146 Surgery - vascular
7x152 Surgery - neurological

II. RISK CLASSIFICATIONS

NOTE: When two or more classifications apply, use the highest-rated classification.

A. Allopathic (M.D.) and Osteopathic (D.O.) Physicians and Surgeons

CLASS 1 - Basic care/no surgery (no obstetrical procedures or surgery other than the incision of boils and superficial abscesses or suturing of skin and superficial fascia).

M.D. CODE	D.O. CODE	
80230		Aerospace Medicine - The branch of medicine which deals with the physiological, medical, psychological and epidemiological (i.e. disease-related) problems in present day air and space travel.
80254	84254	Allergy - A condition in which an individual is sensitive to a substance (or temperature) that does not affect most other people—such as pollen, dust or food.
80256	84256	Dermatology - The branch of medicine that deals with diagnosis and treatment of diseases of the skin. (Not including hair transplants - See Class 3).
80240	84240	Forensic/Legal Medicine - The application of medical principles in law. (Autopsies)
80231		General Preventive Medicine - The branch of medicine which aims at the prevention of disease.
80243	84243	Geriatrics - The branch of medicine that deals with the structural changes, physiology, diseases and hygiene of old age.
80245	84245	Hematology - The branch of medicine that deals with the blood and its diseases.
80232		Hypnosis - A trance-like condition that can be artificially induced, characterized by an altered consciousness, diminished willpower, and an increased responsiveness to suggestion.

CLASS 1 - Basic care/no surgery (continued)

M.D. CODE	D.O. CODE	
80248		Nutrition - The branch of medicine that deals with the act or process of nourishing or taking nourishment, especially the process by which food is assimilated.
80266	84266	Pathology - The branch of medicine that deals with the origin, nature, causes and development of diseases.
80234		Pharmacology - clinical - The branch of medicine concerned with the nature, preparation, administration and effects of drugs.
80235	84235	Physiatry/Physical Medicine/Rehabilitation - Physiatry - The practice of Physical Medicine. Physical Medicine - A consultative, diagnostic, therapeutic medical specialty coordinating and integrating the use of physical therapy (use of light, heat, cold, water, electricity, and exercises) occupational therapy and physical reconditioning in the professional management of the diseased and injured.
80249	84249	Psychiatry - including child - The branch of medicine that deals with the diagnosis, treatment and prevention of mental disorders.
80250		Psychoanalysis - A system used in the treatment of nervous and mental disorders.
80251	84251	Psychosomatic Medicine -The branch of medicine that investigates the reciprocal influences of body and mind in the cause, prevention, treatment and cure of disease.
80236		Public Health - The branch of medicine that deals with the protection and improvement of community health by organized community effort and including preventive medicine and sanitary and social science.

CLASS 2 - Life systems/no surgery (no obstetrical procedures or surgery other than incision of boils and superficial abscesses or suturing of skin and superficial fascia)

M.D. CODE	D.O. CODE	
80237		Diabetes - The branch of medicine that deals with a disease associated with deficient insulin secretion.
80238	84238	Endocrinology - The branch of medicine that deals with the endocrine (ductless) glands (e.g. thyroid) and the various internal secretions.
80420	84420	Family Physicians/General Practitioners - Family Physicians - The medical specialty concerned with the planning and provision of the comprehensive primary health care of all members of a family, regardless of age or sex, on a continuing basis; General Practitioners - The provision of comprehensive medical care as a continuing responsibility regardless of age of the patient or the condition that may temporarily require the services of a specialist. (Not including prenatal - See Class 3).
80239	84239	Family Physicians (old)
80241	84241	Gastroenterology - The branch of medicine that deals with anatomy, physiology and pathology of the stomach and intestines.
.....	.....	General Practitioners (new) - See FP/GP Code XX20
80242	84242	General Practitioners (old)
80244	84244	Gynecology - The branch of medicine that deals with the functions and diseases of women.
80246		Infectious Diseases - Any diseases that are due to the growth and action of microorganisms or parasites in the body, and that may or may not be contagious.
80257	84257	Internal Medicine - The branch of medicine that is concerned with diseases of the internal organs.

M.D. CODE	D.O. CODE	
80258		Laryngology - The branch of medicine that deals with the larynx (throat part, vocal cords), its functions and its pathology.
80259		Neoplastic Diseases - Any diseases that are concerned with any new and abnormal growth, such as a tumor.
80260		Nephrology - The branch of medicine that deals with the kidney and its diseases.
80261		Neurology - including child - The branch of medicine that deals with the nervous system and its disorders.
80262	84262	Nuclear Medicine - The branch of medicine that deals with diagnostic, therapeutic and investigative use of radioactive materials.
80233	84233	Occupational Medicine - The branch of medicine that deals with treatment of work related illnesses and injuries.
.....	.....	Oncology - The sum of knowledge concerning tumors, the study of tumors; (Use Physicians - N.O.C. Code XX268)
80263	84263	Ophthalmology - The branch of medicine that deals with the structure, functions and diseases of the eye.
80289	84289	Ophthalmology - minor surgery
80114		Ophthalmology - surgery
80264		Otology - The branch of medicine that deals with the ear and its diseases.
80265	84265	Otorhinolaryngology - The branch of medicine that treats the ear, nose and throat.
80268	84268	Physicians - N.O.C. - Not otherwise classified.
80269	84269	Pulmonary Disease - Any diseases that are affecting the lungs.

CLASS 2 - Life Systems/no surgery (Continued)

M.D. CODE	D.O. CODE	
80253	84253	Radiology - diagnostic - The branch of medicine that relates to radiant energy and its application especially in the diagnosis and treatment of disease.
80252	84252	Rheumatology - The branch of medicine that treats rheumatism, a disease marked by inflammation of the connective tissue structures of the body, especially the muscles and joints.
80247		Rhinology - The branch of medicine that relates to the nose and its diseases.

CLASS 2A - Pediatrics/no surgery

M.D. CODE	D.O. CODE	
80267	84267	Pediatrics - The branch of medicine that deals with the diseases and hygienic care of children.

CLASS 3 - Minor surgery /assisting in major surgery on own patients

NOTE: Also includes emergency room work up to 16 hours per week.

M.D. CODE	D.O. CODE	
80255	84255	Cardiovascular Disease - no surgery - Any diseases that are pertaining to the heart and blood vessels.
80281	84281	Cardiovascular Disease - Including arterial, cardiac, or diagnostic catheterization.
80282	84282	Dermatology - The branch of medicine that deals with diagnosis and treatment of diseases of the skin (including hair transplants).
80271		Diabetes - The branch of medicine that deals with a disease associated with deficient insulin secretion.

CLASS 3 - Minor surgery/assisting in major surgery on own patients (continued)

M.D. CODE	D.O. CODE	
80272	84272	Endocrinology - The branch of medicine that deals with the endocrine (ductless) glands (e.g. thyroid) and the various internal secretions.
80421	84421	Family Physicians/General Practitioners - Family Physicians - The medical specialty concerned with the planning and provision of the comprehensive primary health care of all members of a family, regardless of age or sex, on a continuing basis; General Practioners - The provision of comprehensive medical care as a continuing responsibility regardless of age of the patient or of the condition that may temporarily require the services of a specialist (including prenatal care and normal vaginal deliveries).
80273	84273	Family Physicians (old)
80274	84274	Gastroenterology - The branch of medicine that deals with the anatomy, physiology and pathology of the stomach and intestines.
80276	84276	Geriatrics - The branch of medicine that dea with the structural changes, physiology, diseases and hygiene of old age.
80277	84277	Gynecology - The branch of medicine that deals with the functions and diseases of women.
80278	84278	Hematology - The branch of medicine that deals with the blood and its diseases.
80279		Infectious Disease - Any diseases that are due to the growth and action of microorganisms or parasites in the body, and that may or may not be contagious.
80283	84283	Intensive Care Medicine/Pulmonary Critical Care - This classification applies to any general practitioner or specialists employed in an intensive care hospital unit. Pulmonary Critical Care - Intensivist specializing in pulmonary medicine.

CLASS 3 - Minor surgery/assisting in major surgery on own patients
(continued)

M.D. CODE	D.O. CODE	
80284	84284	Internal Medicine - The branch of medicine that is concerned with diseases of the internal organs.
80285		Laryngology - The branch of medicine that deals with the larynx (throat part, vocal cords), its functions and its pathology.
	84801	Manipulator - Skillful handling in the adjustment of an abnormality or the bringing about of a desirable condition as the changing of the position of the fetus, the alignment of the fragments of a broken bone, the replacement of a protruding organ (hernia), etc.
80286		Neoplastic Diseases - Any diseases that are concerned with any new and abnormal growth, such as a tumor.
80287		Nephrology - The branch of medicine that deals with the kidney and its diseases.
80288	84288	Neurology - including child - The branch of medicine that deals with the nervous system and its disorders.
80290		Otology - The branch of medicine that deals with the ear and its diseases.
80291	84291	Otorhinolaryngology - The branch of medicine that treats the ear, nose and throat.
80292	84292	Pathology - The branch of medicine that deals with the origin, nature, causes and development of diseases.
80293	84293	Pediatrics - The branch of medicine that deals with the diseases and hygienic care of children.
80533	84533	Physicians - N.O.C. - Not otherwise classified.
.....	.....	Pulmonary Critical Care - See Intensive Care Medicine - Use Code XX283

CLASS 3 - Minor surgery/assisting in major surgery on own patients
(continued)

M.D. CODE	D.O. CODE	
80280	84280	Radiology - diagnostic - The branch of medicine that relates to radiant energy and its application especially in the diagnosis and treatment of disease.
80270		Rhinology - The branch of medicine that relates to the nose and its diseases.
	84802	Sclerotherapy - The use of a chemical irritant (a sclerosant) to produce a hardening of a structure, as by injecting it into a varicose vein. Sclerosant - a medicinal substance which induces inflammation in a tissue and a subsequent hardening or shrinkage.

CLASS 4 - Special Care and Surgery

M.D. CODE	D.O. CODE	
80101		Bronchoesophagology - The branch of medicine which deals with the bronchial tree (body tubes which carry air) and the esophagus (muscular tubular organ which carries food from mouth to stomach).
80115		Colon & Rectal surgery - Surgery pertaining to the colon and rectum.
80102	84102	Emergency Medicine - no major surgery - This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility who does not perform major surgery.
80103		Endocrinology - The branch of medicine that deals with the endocrine (ductless) glands (e.g. thyroid) and the various internal secretions.

CLASS 4 - Special Care and Surgery

M.D. CODE	D.O. CODE	
80117	84117	Family Physicians/General Practitioners - Family Physician - The medical specialty concerned with the planning and provision of the comprehensive primary health care of all members of a family, regardless of age or sex, on a continuing basis; General Practitioner The provision of comprehensive medical care as a continuing responsibility regardless of age of the patient or of the condition that may temporarily require the services of a specialist (including tonsillectomies and adenoidectomies).
80104		Gastroenterology - The branch of medicine that deals with the anatomy, physiology and pathology of the stomach and intestines.
80105		Geriatrics - The branch of medicine that deals with the structural changes, physiology, diseases and hygiene of old age.
80170		Head and Neck Surgery - Surgery of the head and neck.
80106		Laryngology - The branch of medicine that deals with the larynx (throat parts, vocal cords), its functions and its pathology.
80107		Neoplastic Disease - Any diseases that are concerned with any new and abnormal growths such as a tumor.
80108		Nephrology - The branch of medicine that deals with the kidney and its diseases.
80158		Otology Surgery - The branch of medicine that deals with the ear and its diseases.
80159		Otorhinolaryngology Surgery - The branch of medicine that treats the ear, nose and throat.
80534	84534	Physicians - N.O.C. - Not otherwise classified.

CLASS 4 - Special Care and Surgery (Continued)

M.D. CODE	D.O. CODE	
80160		Rhinology Surgery - The branch of medicine that relates to the nose and its diseases.
80145	84145	Urology - The branch of medicine pertaining to the urinary tract of both male and female, and with the genital organs of the male.

CLASS 5 - Anesthesiology

M.D. CODE	D.O. CODE	
80151	84151	Anesthesiology - The branch of medicine specializing in anesthesia-the abolition of sensation or the rendering unconscious by artificial means.

CLASS 6 - Major Surgery

M.D. CODE	D.O. CODE	
80166		Abdominal Surgery - Surgery of the abdominal viscera.
80141		Cardiac Surgery - Surgery of the heart.
80157	84157	Emergency Medicine - major surgery - This classification applies to any general practitioner of specialist primarily engaged in emergency practice at a clinic, hospital or rescue facility who performs major surgery.
80143	84143	General Surgery - N.O.C. - That which deals with surgical problems of all kinds.
80167	84167	Gynecology Surgery - Surgery pertaining to the functions and diseases of women.
80169		Hand Surgery - Surgery of the hand.
80156	84156	Plastic Surgery - N.O.C. - Surgery concerned with the restoration of body structures that are defective or damaged by injury or disease.

CLASS 6 - Major Surgery (continued)

M.D. CODE	D.O. CODE	
80155	84155	Plastic/Otorhinolaryngology Surgery - Surgery pertaining to the restoration or reconstruction of body structures, ear, nose or throat.
80171		Traumatic Surgery - Surgery pertaining to trauma (e.g. a wound or injury).

CLASS 7 - Reserved for future use

CLASS 8 - Critical care and surgery

M.D. CODE	D.O. CODE	
80150	84150	Cardiovascular Disease Surgery - Surgery pertaining to the heart and blood vessels.
80153	84153	Obstetrics/Gynecology Surgery - Surgery pertaining to obstetrics and gynecology.
80168		Obstetrical Surgery - Surgery pertaining to pregnancy and childbirth.
80154	84154	Orthopedic Surgery - The branch of surgery concerned with the preservation and restoration of the function of the skeletal system.
80144	84144	Thoracic Surgery - Surgery pertaining to the chest.
80146		Vascular Surgery - Surgery of the blood vessels within the limbs of the body, or the trunk, neck, abdomen or head.

CLASS 8A - Neurosurgery - including child

M.D. CODE	D.O. CODE	
80152	84152	Neurosurgery - including child - Surgery pertaining to the nervous system.

PART I

BACKGROUND

"Crisis" can be defined as a turning point, a crucial or decisive time. It is in this context that the medical malpractice insurance "crisis" can be seen as an opportunity for problem definition and evaluation, for it is only through an objective look at the market that appropriate conclusions and solutions can be developed.

The concept of a medical malpractice insurance crisis is not a new one. The same concerns which were raised in the mid-1980s -- cost and availability of coverage -- were also raised in the mid-1970s. The solution of the '70s was to create a malpractice insurance fund to directly respond to the problem of availability and cost. The '80s, however, saw an approach designed to attack the underlying costs which drive the premiums through the adoption of what is generically termed tort reform. Data with which to evaluate the effect of the tort reforms of 1986 is not available. However, data regarding the medical malpractice insurance market and medical malpractice claims experience is available through the Insurance Bureau.

Public Act 44 of 1975 required insurers to submit detailed information on medical malpractice claims both when they are initially filed and at the time they are resolved. In 1986, the Legislature amended the reporting requirements to include self-insured entities and every person, other than an insurer, who pays or who has assumed liability to pay a medical malpractice claim. Attorneys who represent either a plaintiff or a defendant in a malpractice action, as individuals, must make initial and closed claim reports to the Insurance Bureau.

In an effort to monitor the medical malpractice insurance market, the 1986 legislation requires the Commissioner of Insurance to prepare a report every two years which describes the condition of the market, contains information regarding specific claims experience from reports filed with the Bureau, and makes recommendations concerning the market. This is the first such report.

The data on claims experience in this report is taken from the Insurance Bureau's data base for the years 1983 through the first six months of 1988. It should be noted that in sections of the report dealing with specific aspects or types of claims, the totals may not add to the totals reported for indemnity, expenses and claim reports by year. This is because not all forms contain entries in all fields.

decreasing the number of doctors it insures in Michigan, as evidenced by a decline in the net premiums written beginning in 1984 despite increases in malpractice rates.

Pricing of Medical Malpractice Insurance for Hospitals

A General Accounting Office report (HRD-86-112 Sept. 1986) indicated that from 1983 to 1985, total inpatient hospital days for the nation as a whole decreased by 13 percent while hospital malpractice insurance costs increased by approximately 57 percent, from $849 million to $1,336 billion. As a result, the average cost for malpractice insurance per inpatient day increased by 85 percent, from $3.02 to $5.60.

To help reduce costs, hospitals took one or more of the following steps: 1) retained some or all of the malpractice risk themselves through self-insurance trusts; 2) switched from an occurrence to a claims-made policy; 3) added or increased deductibles; and 4) decreased coverage limits. Michigan mirrored these national trends as the larger hospitals in the Wayne, Oakland and Macomb areas became self-insured or formed offshore captives. Currently, the Insurance Bureau estimates that over 50 percent of the hospital beds in Michigan are self-insured.

The primary insurer of hospitals in Michigan who remain with conventional malpractice insurance is the Michigan Hospital Association Mutual Insurance Company (MHAMIC). Like the two largest writers of physicians' malpractice insurance in Michigan, MHAMIC is a captive formed by its member insureds to meet their needs for medical malpractice insurance. The only other insurer still writing small amounts of hospital malpractice insurance in Michigan is St. Paul Insurance Company. Argonaut Insurance Company withdrew from the hospital liability market in mid-1985. As Exhibit 1 showed, Argonaut's market share had already decreased dramatically by 1982.

Determining premiums for hospital professional liability insurance is more complex than for physicians' professional liability. As for physicians, base rates are set at limits of $100,000 per occurrence and $300,000 aggregate. The units of exposure are the number of beds available for patients and the number of emergency room and outpatient visits. Factors are then applied to the base rate to determine rates for higher limits of liability. Other factors may also be used, such as experience modification factors to reflect each hospital's recent loss experience, discounts for deductibles and claims-made factors which provide for a reduced premium in the first few years of a claims-made policy. Special characteristics of each hospital, such as number of bassinets, number of psychiatric or rehabilitation beds, and other special services or programs provided by the hospital are also considered in calculating final premiums for hospital liability insurance.

Like physicians' medical malpractice insurance, hospital malpractice insurance is also rated by territory. MHAMIC currently uses three rating territories:

Territory 1. Macomb, Oakland and Wayne counties.

Territory 2. The area within the limits of the following cities:

Ann Arbor	Jackson	Niles
Battle Creek	Kalamazoo	Port Huron
Bay City	Lansing	Saginaw
Benton Harbor	Midland	St. Joseph
Flint	Muskegon	Ypsilanti
Grand Rapids		

Territory 3. Remainder of state.

Exhibit 8 provides a rate history for MHAMIC for basic limits of coverage per acute care bed. While this is overly simplistic, it does provide a general indication of the magnitude and direction of final premiums. An interesting development is that MHAMIC lowered its acute care bed rate in 1988 by 10 percent for Territory 1 and 2, and by 20 percent for Territory 3.

EXHIBIT 8

MICHIGAN HOSPITAL ASSOCIATION MUTUAL INSURANCE COMPANY
ACUTE CARE BED RATE HISTORY

Acute Care Bed Rate Charged for $100,000/$300,000 Limits, Occurrence Form

Rating Period	Territory 1	Territory 2	Territory 3
1977-1978	$ 450	$	$
1979-1981	399		
1982	465		
1983	1,055		
1984	1,368	1,368	1,053
1985	2,736	1,847	1,316
1986	3,420	2,309	1,645
1987	4,617	3,118	2,221
1988	4,155	2,806	1,777

Note: Prior to 1984, MHAMIC did not differentiate acute care bed rates by territory.

Merit Rating

One of the many requirements of P.A. 173 of 1986 was that all commercial liability insurers, including medical malpractice insurers, adopt merit rating plans for their commercial liability

insurance products. Section 2404(1) of the Insurance Code, MCLA 500.2404, specifies that "[a] merit rating plan required under this section shall adjust rates for commercial liability insurance policies on the basis of risk management techniques implemented by the insured."

In addition, medical malpractice insurers were permitted to surcharge their policyholders based on their claim experience under certain limited circumstances. Section 2404(2) listed four requirements which such a surcharge must meet:

1. The surcharge plan must be filed with the commissioner.

2. The surcharge must not be based on an action that was filed more than three years before the issuance or renewal of the policy.

3. The surcharge must not be based on an action for which the insured has been found not liable or which was settled or dismissed without indemnity being paid on behalf of the insured.

4. The surcharge must not be based on an action for which the insurer paid in indemnity and loss adjustment expenses an amount less than 51 percent of the annual premium paid for the policy covering the action.

Medical malpractice insurers have filed experience rating formulas which compare losses meeting the above criteria to expected losses under the policy in order to calculate credits and debits.

The merit rating plans based on risk management activities accept a variety of measures aimed at reducing or eliminating medical malpractice claims. Credits are given for completion of approved risk management seminars, approved office risk analysis and education programs, and approved closed claim review programs. Implementation and use of an approved patient information system is also a basis for merit rating credit. Specialists may be eligible for credits by complying with risk management and loss prevention guidelines adopted by their recognized medical specialty societies. Exhibit 9 shows examples of merit rating credits given by the major medical malpractice insurers.

Claims-made Policy Forms

A recent development affecting the pricing of medical malpractice insurance for physicians and other health practitioners has been the approval by the Insurance Bureau of the claims-made policy form for this type of coverage. Historically, medical malpractice liability insurance was offered on an occurrence basis, with the policy indemnifying the insured for all loss-producing events which occurred while the policy was in force, regardless of when the claim for the loss was finally made.

EXHIBIT 9

MERIT RATING PLANS

Recommendations for Hospital Insurers

ISO

Maximum credit	25%
Examples:	10% for medical audit system including surgical procedures tied to physician credentialing
	2% for continuing education
	5% for JCAH or AOA accreditation
	10% for compliance with loss prevention recommendations

MPMLC

Maximum credit	8%
Examples:	Completion of approved office risk analysis
	Attendance at approved risk management seminar carrying 3 CME credits
	Closed claim review carrying 2 CME credits

MHAMIC

Maximum credit	25%

MEDICAL PROTECTIVE

Maximum credit	5% for completion of 2 eight-hour risk management seminars

PICOM

Maximum credit	10%
Examples:	5% for level one program - completion of internal office review, attendance at risk management seminar minimum four hours
	10% for level two program - completion of two characteristics of level one program plus completion of a specialty society risk management seminar or self-assessment survey

A claims-made policy indemnifies the insured for losses for which a claim is made while the policy is in force, provided that the loss producing event occurred after the initial date of coverage under the policy. For liability insurance which typically has a lag between when an incident occurred and when a claim is made, this has the effect of moving losses into later years of coverage under the policy. As a result, there is a substantial discount for claims-made policy premiums compared to those of occurrence policies during the early years of a policy. The discount tapers off until, at about five years, the claims-made rates are virtually identical to occurrence rates. The effect of claims-made policies on malpractice rates for physicians is illustrated by Exhibit 10.

EXHIBIT 10

CLAIMS MADE RATE FACTORS
AS A PERCENTAGE OF OCCURRENCE PREMIUMS

Year of Coverage	MPMLC	PICOM	Butterworth
1st	50%	50%	50%
2nd	70%	70%	70%
3rd	85%	85%	85%
4th	90%	90%	95%
5th and beyond	95%	95%	100%

SOURCE: Rates on file with the Michigan Insurance Bureau as of 12/31/88.

When a claims-made policy ends, however, it is necessary for the policyholder to pay additional premiums to buy coverage for claims which may be reported after that date on events which occurred while the policy was in force. A claims-made policy in effect changes the payment pattern for liability insurance, reducing the cost in the early years and increasing the cost at the end of the contract.

The advantages of a claims-made policy to the insured are the obvious decrease in cost in the early years which can be important to persons just starting a business or profession, and the ability to increase protection limits as inflation or assets require. The major disadvantage is the need to purchase coverage for an "extended reporting period" for claims which are made after the policy ends. A policyholder with a claims-made policy faces a potentially large expense for coverage for this extended reporting period at retirement, death, cessation of business, or even when changing insurance carriers.

Medical malpractice insurers offering claims-made policies have attempted to alleviate some of the disadvantages of these policies by waiving the premium for the extended reporting period in the event of death or disability of the insured or for normal retirement, provided the covered person was insured by the company for at least five years prior to this event. They have

also offered graded premiums for the extended reporting period during the first few years of practice for new physicians who have just completed their medical training.

There are fewer disadvantages to a claims-made policy for hospitals than for doctors. Hospitals as corporations have a theoretically perpetual life and do not face the problems of eventual retirement and death. Hospitals also do not need to be concerned about the possible difficulty of relocating, as a physician might. For these reasons, claims-made policies have been accepted for use in insuring hospitals for a longer time than they have been used to insure physicians.

Although claims-made policies have made major inroads in insuring Michigan physicians, as well as most other types of health-related professions, all three of the major physician insurers continue to insure some portion of their policyholders on an occurrence basis. PICOM has been most active in marketing the claims-made form, and will accept new insureds only on that basis. MPMLC offers both forms of coverage, and Medical Protective uses only occurrence policies. Of the newer participants, Continental offers only the claims-made form, while it appears that Butterworth Insurance Exchange will carry both occurrence and claims-made. It seems that the two different forms of coverage will be able to co-exist in the Michigan malpractice insurance market, at least for the foreseeable future.

Demand for Malpractice Insurance

No discussion of a marketplace would be complete without some consideration of the demand for the product. For medical malpractice insurance, demand is correlated with the number of hospitals, physicians and other health care providers. Exhibit 11 was prepared by the Office of Health and Medical Affairs. Using data supplied by the American Medical Association and the American Osteopathic Association, it reports the growth in the number of physicians in Michigan over a 15 year period. Despite the large increases in the cost of medical malpractice insurance over that period, the number of active physicians in Michigan has continued to rise.

Exhibit 12 is ambiguous as to whether medical malpractice insurance costs may be redistributing the number of physicians in certain specialties. While the total number of M.D.s in Michigan increased by 39.2 percent over the 12 year period shown, some specialties such as cardiovascular and pulmonary medicine increased by more than 100 percent while growth in occupational medicine was nearly flat. Among the surgical specialities, general surgery experienced the least growth at 10.6 percent, followed by obstetrics and gynecology at 17 percent. However, orthopedic surgery and plastic surgery, both fairly highly rated for malpractice insurance purposes, experienced above average growth.

Unlike physicians, the number of hospitals in Michigan has decreased in the fifteen years between 1973 and 1988. In 1973

there were 247 hospitals in the state, compared to 204 in 1988. The number of available hospital beds decreased from 41,331 in 1973 to 37,556 in 1988, or an average reduction of about 88 beds per closed hospital. It is clear that the hospitals which have closed have generally been smaller hospitals, which are the ones most likely to have remained in the insurance marketplace, using conventional insurance to meet their malpractice insurance needs. These small hospitals have succumbed to a number of economic pressures. Given the recent rate decreases made by the principal writer of hospital malpractice insurance in Michigan, however, it does not seem that malpractice costs will be the critical factor in the continued existence of small hospitals in the near future.

EXHIBIT 11

PHYSICIAN SUPPLY IN MICHIGAN AND THE U.S., 1971-1986

Category	1971	1981	1986	Total Change 1971-1986
Michigan				
Active Physicians				
DOs	2,168	3,040	3,401	56.9%
MDs	11,356	15,173	16,509	45.4%
Total	**13,524**	**18,213**	**19,910**	**47.2%**
Population	8.974	9.210	9.139	1.8%
Physicians per 100,000 Population	50.7	197.8	217.9	44.6%
United States				
Active Physicians				
DOs	12,560	18,275	23,647	88.3%
MDs	324,883	449,047	521,030	60.4%
Total	**337,443**	**467,322**	**544,677**	**61.4%**
Population	206,827	229.637	241.096	16.6%
Physicians per 100,000 Population	163.2	203.5	225.9	38.5%

NOTE: MD data is for 12/31/71, 12/31/81 and 12/31/86. DO data is for 1971, 3/31/81 and 8/1/86. Population data is for 7/1/71, 7/1/81 and 7/1/86.

SOURCE: American Medical Association, "Physician Characteristics and Distribution in the U.S." (Data adjusted by OHMA for address unknown, federal and unclassified physicians.)

American Osteopathic Association, "Yearbook and Directory of Osteopathic Physicians" and "Osteopathic Physicians in the United States: Report on a 1971 Survey." (Data adjusted by OHMA for federal, unclassified and non-responding physicians.)

Office of Health and Medical Affairs, 12/88

EXHIBIT 12

MICHIGAN PHYSICIAN ACTIVITY BY SPECIALTY

Year	1974	1975	1976	1977	1978	1979
Total Phys	12,608	13,176	13,519	13,594	14,290	14,593
Specialty						
Cardiovascular	184	212	188	200	242	239
Dermatology	153	161	167	176	186	193
Gastroent	51	67	60	72	91	94
Internal Medicine	1,676	2,000	2,145	2,245	2,297	2,516
Pediatrics	692	738	761	794	828	887
Pulmonary	47	46	47	48	81	85
Surgical						
General Surgery	1,184	1,274	1,311	1,266	1,248	1,300
Neuro Surgery	84	86	88	104	97	102
Obstetrics & Gynecology	859	903	931	942	965	1,011
Opthalmology	346	364	373	357	365	395
Orthopedic Surgery	315	329	338	356	379	412
Plastic Surgery	68	73	81	84	90	109
Urology	206	214	219	231	240	246
Other						
Anesthesiology	343	332	356	394	399	428
Diag Radiology	79	91	95	121	167	244
Neurology	84	96	102	105	114	142
Occupational Medicine	131	125	132	122	136	140
Psychiatry	790	783	803	802	828	901
Pathology	393	405	405	414	416	436
Radiology	469	475	491	478	430	421

Exhibit 12 (continued)

MICHIGAN PHYSICIAN ACTIVITY BY SPECIALTY

Year	1980	1981	1982	1983	1984	1985	1986
Total Phys	15,347	15,758	16,208	16,512		17,206	17,549
Specialty							
Cardiovascular	289	296	325	334		354	396
Dermatology	201	221	231	233		229	234
Gastroent	115	122	132	140		154	168
Internal Medicine	2,577	2,651	2,813	2,854		3,040	2,973
Pediatrics	942	945	967	974		1,066	1,058
Pulmonary	110	111	127	125		121	134
Surgical							
General Surgery	1,303	1,317	1,359	1,354		1,374	1,310
Neuro Surgery	107	111	124	120		120	121
Obstetrics & Gynecology	1,057	1,057	1,067	1,100		1,128	1,091
Opthalmology	410	411	430	432		449	452
Orthopedic Surgery	431	449	494	502		516	515
Plastic Surgery	102	105	116	120		123	130
Urology	257	262	266	273		281	268
Other							
Anesthesiology	435	455	496	510		529	567
Diag Radiology	261	303	388	422		492	523
Neurology	154	156	179	178		202	224
Occupational Medicine	137	142	129	126		129	134
Psychiatry	905	902	951	987		956	995
Pathology	449	460	479	486		502	497
Radiology	420	395	366	368		350	285

SOURCE: AMA, "Physician Characteristics and Distribution in the U.S."

PART III

MALPRACTICE CLAIMS EXPERIENCE

One of the purposes of this report is to provide an overview and analysis of medical malpractice actions for which reports have been filed with the Insurance Bureau since January 1, 1983. This will be done in two sections. The first section will review data obtained from Form A, the initial report of court action. The second section will consider data obtained from Form B, the closed claim report. It should be noted that self-insured institutions and individuals were not required to report malpractice actions until July, 1986. Therefore, the data base does not contain self-insured experience prior to that date. The data reporting forms are shown in Appendix A.

Initial Report of Court Action

This initial report, referred to as Form A, is required to be filed within thirty days after a complaint is filed in court. The information submitted on this report includes the defendant's name, specialty, date of incident, nature of the complaint and the county and court in which the complaint is filed.

The numbers below indicate the total initial reports filed from January 1, 1983 to June 30, 1988.

TABLE 1

TOTAL INITIAL REPORTS BY YEAR

Year	Records Filed
1983	1,925
1984	2,999
1985	3,105
1986	3,629
1987	2,397
1988 (through 6/88)	871
TOTAL	**14,926**

It appears from this data that the number of malpractice actions filed each year has begun to decrease, having peaked in 1986. It should be noted, however, that the high number of claims filed in 1986 may be partially attributed to the effort by the plaintiff's bar to file cases prior to the effective date of the tort law changes.

ACTIONS BY COUNTY

A review of the claims filed by county shows that almost two-thirds of all actions are filed in three counties -- Wayne, Oakland and Macomb. The ten counties with the highest number of claims filed account for 83 percent of all claims. Twenty-four counties showed ten or fewer total claims for the period January 1, 1983 to June, 30 1988. Although information on things such as the number of patient visits, services performed and emergency treatments given may be more meaningful for purposes of comparing actions by county, lack of such data requires that substitute variables such as population and availability of medical services be considered instead. Not surprisingly, the counties with the highest number of claims are those with large urban centers, medical schools and larger hospitals. Those with the fewest claims tend to be in the largely rural areas of the northern lower peninsula and in the upper peninsula. Initial actions by county, by year, for the ten counties with the most claims are shown below:

TABLE 2

INITIAL ACTIONS BY YEAR -- TEN LARGEST COUNTIES

County	1983	1984	1985	1986	1987	1988	Total
Wayne	883	1,421	1,408	1,625	1,114	347	6,798
Oakland	276	397	415	502	316	136	2,042
Macomb	116	190	207	202	126	43	884
Genesee	72	154	116	144	110	35	631
Ingham	53	107	133	110	65	16	484
Kent	42	72	85	100	74	35	408
Washtenaw	60	66	75	92	53	20	366
Kalamazoo	27	26	77	60	46	18	254
Jackson	37	40	70	53	26	6	232
Saginaw	32	43	38	43	28	42	226
TOTAL							12,325

ACTIONS BY SPECIALTY

The Form A data shows that the largest number of claims are filed against six specialties. Claims by year by specialty are shown below:

TABLE 3

INITIAL ACTIONS BY YEAR -- SIX SPECIALITIES

Specialty	1983	1984	1985	1986	1987	1988	Total
Obstetrics	198	285	257	276	181	88	1,285
Internal Med*	159	236	183	93	26	12	709
Gen Practice*	154	327	113	62	10	8	674
Internal Med**	2	3	144	247	176	60	632
Orthopedics	100	182	113	106	59	20	580
Dentistry	131	107	113	68	21	13	453

* minor surgery
** no surgery

The decreasing number of claims filed against these specialists in 1987 and 1988 reflect the overall trend. It is interesting to note the pattern that occurred within each specialty, however.

Obstetricians continue to have the highest number of claims, but are following the overall pattern of fewer claims for the years 1987 and 1988. In 1984, more claims were filed against general practitioners doing minor surgery than any other specialist, having more than doubled since 1983. Since 1984, however, the number of claims against this specialty have decreased dramatically.

Internal medicine specialists performing minor surgery show a claim pattern similar to that of general practitioners performing minor surgery, with the highest number of claims being filed in 1984 and a dramatic decrease in claims in the years following. Internists performing no surgery, however, have experienced considerably different claim activity. Form A data shows only two claims filed against internists performing no surgery in 1983 and three claims in 1984. This increased to 144 claims in 1985, and in 1986 and 1987 they had the second highest number of claims filed with 247 and 176, respectively.

There are several possible explanations for the dramatic reduction in claims filed against general practitioners and internists performing minor surgery. It could be that physicians have made even more efforts in risk management, resulting in fewer patient difficulties and therefore fewer claims. It is also possible that the tort reform changes of 1986 have had an impact on the number of initial claims. Another factor could be that fewer general practitioners and internists are performing minor surgery than in previous years. Because there is no way to determine how many of these physicians have discontinued their surgical practice, we are unable to determine whether the ratio of claims to the number of practitioners has changed over the six-year period.

The factors cited above cannot totally explain the increase in claims experienced by internists performing no surgery, however. Interestingly, the sudden increase in claims against these practitioners coincides with the decrease in claims against general practitioners and internists performing minor surgery. One explanation could be that surgery is not necessarily the activity giving rise to the claims against internists. In fact, looking at the combined data for both classes of internists, a pattern of claim experience very similar to overall claim experience emerges. A review of the nature of initial claims shows that the treatment itself, misdiagnosis, and delay in diagnosis were the most common sources of medical malpractice claims against general practitioners and internists, regardless of whether they perform surgery.

Another somewhat related factor in the claim experience of internists could be a result of risk management on the part of

other physicians. It may be that general practitioners are referring more patients to internists (and possibly other specialists) than they have in the past. Again, this is not verifiable with data available to the Bureau.

Closed Claim Reports

The closed claim report, referred to as Form B, is required to be filed within 30 days after any judgment, settlement or dismissal of a claim. The information submitted on this report includes identifying information on the insured, how the claim was resolved, the type and severity of the injury, and indemnity and expense payments.

The numbers below indicate the total closed claims filed, total indemnity paid, and total allocated expenses per year from January 1, 1983 to June 30, 1988.

TABLE 4

TOTAL CLOSED CLAIMS, INDEMNITY & ALLOCATED EXPENSES BY YEAR

Year	Closed Claims	Indemnity	Allocated Expenses
1983	1,740	$ 30,435,447	$ 21,833,548
1984	1,182	14,027,677	6,844,007
1985	2,177	59,056,089	18,444,727
1986	2,029	43,191,136	23,338,690
1987	3,586	106,137,543	68,592,244
1988 (through 6/88)	1,889	46,998,467	40,708,557
Total	**12,603**	**$299,846,359**	**$179,761,773**

TIME INTERVAL

It has been said that medical malpractice suits are more costly because they are more time-consuming than many other types of liability litigation. A review of the Insurance Bureau's closed claims data base (1983-1988) for the purpose of examining the length of time from the date of injury to the date of closure reveals that only 1 percent of malpractice actions are closed within one year and 5 percent are closed within two years. Approximately half of the cases take three to five years after date of injury to resolve.

Table 5 shows how many claims were closed during each 180 day interval.

TABLE 5

NUMBER OF CLAIMS CLOSED
180 DAY INTERVALS

Interval (Days)	Count
0 - 180	25
181 - 360	74
361 - 540	170
541 - 720	357
721 - 900	675
901 - 1,080	1,066
1,081 - 1,260	1,519
1,261 - 1,440	1,641
1,441 - 1,620	1,687
1,621 - 1,800	1,493
1,801 - 1,980	1,085
1,981 - 2,160	716
2,161 - 2,340	495
2,341 - 2,520	378
2,521 - 2,700	270
2,701 - 2,880	226
2,881 - 3,060	161
3,061 - 3,240	149
3,241 - 3,420	130
3,421 - 3,600	86
Over 3,600	462
Totals	**12,865**

Based on the available data, the length of time it takes to resolve a medical malpractice claim does not necessarily have a direct bearing on the ultimate indemnity. While it is true that the average indemnity for cases resolved within one year is considerably lower than for other time intervals, the average indemnity does not rise proportionately with the length of time between injury and resolution. In fact, average indemnity for cases resolved in three and one-half years or more generally remains between $20,000 and $40,000, regardless of the length of time. The reason for this is the fact that there are as many small awards (less than $5,000) as large ones for any given time interval. The median indemnity for cases resolved in three and one-half years or less is $0, and does not rise above $5,000 until cases almost ten years old are taken into account.

It could be assumed that the cases which result in an indemnity of $1 million or more would be the most complicated and therefore take longer to resolve. The data reported to the Insurance Bureau would not support such an assumption. Indemnity payments of $1 million or more are made in cases resolved within two and one-half years as well as those taking eight years to resolve. Exhibit 13 illustrates the range of indemnity payments in 180-day intervals.

EXHIBIT 13

INDEMNITY BY TIME INTERVAL
BETWEEN DATES OF INJURY AND CASE CLOSURE

Interval (Days)	Average	Median	Minimum	Maximum
0 - 180	9,068	0	0	85,000
181 - 360	3,587	350	0	35,000
361 - 540	13,130	0	0	500,000
541 - 720	18,488	0	0	750,000
721 - 900	17,697	0	0	1,177,733
901 - 1080	17,304	0	0	900,000
1081 - 1260	17,899	0	0	750,000
1261 - 1440	19,224	1,000	0	1,000,000
1441 - 1620	21,169	2,000	0	837,887
1621 - 1800	27,118	4,000	0	1,000,000
1801 - 1980	23,743	2,500	0	690,689
1981 - 2160	29,065	3,800	0	900,000
2161 - 2340	35,599	5,000	0	682,078
2341 - 2520	30,844	1,676	0	1,293,000
2521 - 2700	29,945	899	0	949,590
2701 - 2880	27,379	2,846	0	405,243
2881 - 3060	52,271	2,500	0	2,354,474
3061 - 3240	34,338	4,000	0	733,530
3241 - 3420	32,557	1,125	0	885,248
3421 - 3600	37,705	1,750	0	966,743
Over 3600	40,181	6,000	0	596,446

Like indemnity payments, based on the Bureau's claim data, allocated expenses do not appear to be directly related to the length of time between injury date and resolution. For cases resolved within one year, average expenses are noticeably lower than for cases taking longer to resolve. With one exception, average allocated expenses are less than $25,000 regardless of time interval. Exhibit 14 shows average allocated expenses in 180-day time intervals.

These averages should be looked at with caution, however, because the actual allocated expenses for individual claims vary greatly within each time interval. This is demonstrated by the standard deviation. The smaller the standard deviation, the closer the actual numbers are clustered around the average; the larger the standard deviation, the wider the distribution. As the chart shows, allocated expenses are neither consistent within a given time interval nor across the data base as a whole. This is to be expected, since the cost to defend a particular claim depends in large part on the nature of the claim itself.

CLAIM RESOLUTION

The overwhelming majority of medical malpractice claims are resolved through settlement by the parties, although 1987 and 1988 show a decrease in the percentage which are settled. As indicated in Table 6, through 1986, over 90 percent of claims closed each year were settled, while only a small number were resolved by trial verdict, mediation or arbitration.

TABLE 6

CLOSED CLAIM RESOLUTION

Resolution	1983	1984	1985	1986	1987	1988
Settled by Mediation	22	52	39	27	247	181
Settled by Parties	709	933	1,892	1,800	3,034	1,512
Trial Verdict	2	27	115	135	194	144
Arbitration	5	8	10	18	18	11
	738	1,020	2,056	1,980	3,493	1,848

The data show that the percentage of cases resolved through mediation has increased from 1 percent in 1986, to 7 percent in 1987, and 10 percent for the first half of 1988, which may be attributable to the mandatory mediation provisions of Public Act 178 of 1986. It is interesting, however, that the increased mediation has not resulted in a decrease in cases resolved by trial verdict. Instead, there appears to be a shift from "settlement" to "mediation."

EXHIBIT 14

ALLOCATED EXPENSES BY TIME INTERVAL BETWEEN DATES OF INJURY AND CASE CLOSURE

Interval (Days)	Count	Average	Std.Dev
0 - 180	25	4,502	6,010
181 - 360	74	4,096	9,211
361 - 540	170	6,507	26,554
541 - 720	357	7,071	48,273
721 - 900	675	6,806	25,089
901 - 1,080	1,066	9,183	60,330
1,081 - 1,260	1,519	11,573	81,067
1,261 - 1,440	1,641	11,710	88,771
1,441 - 1,620	1,687	15,383	137,610
1,621 - 1,800	1,493	16,628	138,792
1,801 - 1,980	1,085	13,440	83,075
1,981 - 2,160	716	16,362	60,155
2,161 - 2,340	495	16,309	67,925
2,341 - 2,520	378	18,721	127,303
2,521 - 2,700	270	13,817	30,377
2,701 - 2,880	226	17,313	87,082
2,881 - 3,060	161	23,181	148,797
3,061 - 3,240	149	21,576	110,150
3,241 - 3,420	130	11,010	11,943
3,421 - 3,600	86	71,801	563,514
Over 3,600	462	13,499	82,243

CLOSED CLAIMS - SEVERITY OF INJURY

Form B establishes nine categories by which to describe the severity of the injury giving rise to each claim. They are:

1 - **Emotional Only** - Fright, no physical damage.

2 - **Temporary-Insignificant** - Lacerations, contusions, minor scars, rash, no delay.

3 - **Temporary-Minor** - Infections, mis-set fracture, fall in hospital. Recovery delayed.

4 - **Temporary-Major** - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.

5 - **Permanent-Minor** - Loss of fingers, loss or damage to organs. Includes nondisabling injuries.

6 - **Permanent-Significant** - Deafness, loss of limb, loss of eye, loss of one kidney or lung.

7 - **Permanent-Major** - Paraplegia, blindness, loss of two limbs, brain damage.

8 - **Permanent-Grave** - Quadriplegia, severe brain damage, lifelong care or fatal prognosis.

9 - **Death**

Table 7 shows the distribution of closed claims by severity.

TABLE 7

NUMBER OF CLOSED CLAIMS BY SEVERITY

Category	1983	1984	1985	1986	1987	1988
1	59	39	69	59	95	61
2	79	67	93	90	149	92
3	417	315	471	439	678	313
4	121	93	155	172	258	126
5	256	185	382	299	506	220
6	186	133	246	203	465	231
7	83	39	139	134	270	164
8	60	23	66	52	151	77
9	453	274	503	526	946	565

Claims for death of the patient constitutes 26 percent of the closed claims for the five and one-half year period, the largest severity category. Category 3, Temporary-Minor, had the second highest number of claims (21%). It is interesting to note that there are almost as many claims for minor injuries as there are for major ones. Categories 1, 2, 3 and 5 contain 40 to 50 percent of the total closed claims each year.

In general, the claims for minor injuries account for 30 percent or less of the total indemnity paid in a given year. The percentage they represent of total expenses, however, is somewhat higher. Table 8 shows the percentage minor claims categories 1, 2, 3 and 5 represent of the total expenses and total indemnity payments.

TABLE 8

MINOR CLAIMS AS A PERCENTAGE OF TOTAL INDEMNITY AND TOTAL ALLOCATED EXPENSES

Year	% of Total Indemnity	% of Total Allocated Expenses
1983	21%	26%
1984	31%	42%
1985	18%	38%
1986	42%	58%
1987	29%	40%
1988	14%	35%

The data suggests that while minor injuries do receive lower indemnity payments, the expenses associated with these claims do not necessarily reflect the level of severity.

Appendix C shows indemnity and expense totals by category by year.

EXPERIENCE IN LARGER COUNTIES

The indemnity and expense costs associated with medical malpractice claims in the larger counties -- particularly Wayne, Oakland and Macomb -- continues to be a major topic of discussion. It is therefore worthwhile to look at the larger counties separately and to compare them to claims in the remainder of the state as well as the state as a whole.

A review of closed claims by county shows that over sixty percent of all claims closed are in Wayne, Oakland and Macomb counties. Not surprisingly, the ten counties with the highest number of closed claims are the same counties with the highest number of initial claims. These counties account for almost three-fourths of the total number of closed claims in each of the years studied. Since the number of closed claims reflects, in large part, the amount of litigation in an area, a more accurate measure of the cost of medical malpractice is the number of claims closed with an indemnity greater than $0. The expenses incurred in conjunction with malpractice claims and the following chart shows the total number of closed claims and the number of claims closed with an indemnity greater than $0.

Data on the total number of closed claims and the number of claims closed with an indemnity greater than $0 shows that, in general, 50 to 60 percent of claims closed between 1983 and 1988 actually involve payment of an indemnity to the claimant. This holds true whether one looks at the ten largest counties individually or as a group, the remainder of the state, or the state as a whole. Exhibit 15 shows the number of closed claims and the number of closed claims with an indemnity greater than $0 for the ten largest counties, the remainder of the state, and the state as a whole.

The amount of indemnity paid in the largest counties as a percentage of all indemnity paid tracks very closely with the counties' proportion of closed claims. Wayne, Oakland and Macomb counties account for 55 to 60 percent of the total indemnity paid each year. The total indemnity paid in the ten largest counties accounts for over 75 percent of the statewide total. Exhibit 16 shows total indemnity paid for the ten largest counties, the remainder of the state, and the state as a whole.

Allocated expenses for the largest counties also track closely with the counties' proportion of closed claims. Wayne, Oakland and Macomb counties on average account for just over 50 percent of the total allocated expenses for the state. The allocated

expenses in the ten largest counties account for approximately 75 percent of the statewide total. Exhibit 17 shows total expenses for the ten largest counties, the remainder of the state and the state as a whole.

OBSTETRICAL CLAIMS

Birth-related injuries have been the focus of many efforts to develop legislation to reduce the cost of malpractice insurance in general, and the amount charged to obstetricians and gynecologists in particular. It is therefore useful to look at closed claims in this area to determine if this is a critical element in the medical malpractice "crisis." The data in this section includes all closed claims with the injury designated as "obstetrical," and claims with "misdiagnosis" and "delay in diagnosis" as the injury designation which are also showing "labor and delivery room" as the location (hereinafter referred to as OB claims).

The following table shows the total indemnity, allocated expenses and number of closed claims by year.

TABLE 9

CLOSED CLAIMS
OBSTETRICAL TOTAL INDEMNITY & EXPENSES BY YEAR

Year	Indemnity	Expenses	Claims Closed
1983	1,498,614	381,906	70
1984	999,386	224,326	32
1985	808,250	141,196	12
1986	2,863,376	596,054	37
1987	9,664,897	4,042,411	184
1988	6,058,835	1,702,860	124
Total	**21,893,358**	**7,088,753**	**459**

As the table indicates, the number of OB claims varies significantly from year to year. This should not be surprising since there are many variables -- including size of court dockets and the number, nature and complexity of cases in process -- which could determine how many claims are closed each year. However, this could be said of all malpractice actions. Therefore, it is interesting to note that, with the exception of 1988 which is not a complete year, the number of OB claims as a percentage of all closed claims is 5 percent or less each year. The total number of OB claims closed in the period from 1983 through the middle of 1988 represents 4 percent of all claims closed in those years.

EXHIBIT 15

COMPARISON OF TOTAL CLAIMS CLOSED AND CLAIMS CLOSED WITH INDEMNITY GREATER THAN $0

COUNTY		1983	1984	1985	1986	1987	1988	TOTAL
Wayne	Total Closed	717	490	897	805	1,505	794	5,208
	Closed w/Ind>$0	519	267	514	399	726	398	2,823
Oakland	Total Closed	237	170	292	264	553	294	1,810
	Ind>$0	147	95	155	141	235	124	897
Macomb	Total Closed	109	94	142	150	181	116	792
	Ind>$0	70	54	82	79	90	53	428
Genesee	Total Closed	54	42	100	78	117	92	483
	Ind>$0	40	24	46	41	57	30	238
Ingham	Total Closed	57	38	55	70	138	62	420
	Ind>$0	33	25	39	33	62	29	221
Kent	Total Closed	56	30	78	52	105	46	367
	Ind>$0	42	16	45	38	54	23	218
Washtenaw	Total Closed	40	24	63	50	126	48	351
	Ind>$0	21	8	33	30	70	24	186
Kalamazoo	Total Closed	39	19	27	31	45	31	192
	Ind>$0	27	6	21	22	19	16	111
Jackson	Total Closed	15	25	29	35	43	30	177
	Ind>$0	9	18	15	18	22	17	99
Saginaw	Total Closed	23	17	43	36	33	21	173
	Ind>$0	13	10	24	19	16	11	93
10 Co. Total	Total Closed	1,347	949	1,726	1,571	2,846	1,534	9,973
	Ind>$0	921	523	974	820	1,351	725	5,314
Remainder of State	Total Closed	393	233	451	458	740	355	2,630
	Ind>$0	260	144	248	241	381	154	1,428
Statewide	Total Closed	1,740	1,[illegible]	2,177	2,029	3,586	1,88	12,603
	Ind>$0	1,181	[illegible]	1,222	1,061	1,732	879	6,742

EXHIBIT 16

TOTAL INDEMNITY PAID

COUNTY	1983	1984	1985	1986	1987	1988	TOTAL
Wayne	14,620,929	5,233,291	24,990,303	17,311,447	41,320,905	20,104,325	123,581,200
Oakland	3,170,317	1,879,344	6,932,095	5,672,440	12,534,959	5,792,954	35,982,109
Macomb	902,522	902,832	2,212,983	2,949,763	3,377,341	2,051,262	12,396,703
Genesee	790,836	603,575	2,403,456	3,315,664	4,471,153	1,724,371	13,309,055
Ingham	1,653,358	625,204	2,538,852	2,141,142	5,399,334	1,915,920	14,273,810
Kent	589,523	657,945	2,303,967	1,689,867	2,734,236	1,851,119	9,826,657
Washtenaw	706,899	157,175	1,374,678	901,000	5,138,696	1,272,989	9,551,437
Kalamazoo	459,558	289,994	2,004,136	660,499	3,037,499	599,500	7,051,186
Jackson	199,189	281,546	1,089,558	555,300	1,049,500	1,166,009	4,341,102
Saginaw	651,885	447,400	1,086,630	358,500	1,432,231	704,050	4,680,696
10 Co. Total	23,745,016	11,078,306	46,936,658	35,555,622	80,495,854	37,182,499	234,993,955
Remainder of State	6,690,431	2,949,371	12,119,431	7,635,514	25,641,689	9,815,968	64,852,404
Statewide	30,435,447	14,027,677	59,056,089	43,191,136	106,137,543	46,998,467	299,846,359

EXHIBIT 17

ALLOCATED EXPENSES

COUNTY	1983	1984	1985	1986	1987	1988	TOTAL
Wayne	8,943,853	2,486,392	6,452,033	5,856,678	19,189,402	7,402,845	50,331,203
Oakland	2,949,955	1,122,694	2,202,908	2,345,571	10,143,119	8,283,944	27,048,191
Macomb	670,080	601,531	1,152,158	1,126,606	2,871,670	8,018,072	14,440,117
Genesee	624,585	264,158	2,936,074	3,328,009	6,606,325	985,059	14,744,210
Ingham	827,312	283,375	485,927	1,655,832	4,989,634	5,249,933	13,492,013
Kent	414,616	179,238	381,714	1,369,682	1,663,456	378,134	4,386,840
Washtenaw	416,944	77,977	407,386	227,514	1,124,690	520,412	2,774,923
Kalamazoo	482,349	142,180	278,613	838,827	1,884,928	340,341	3,967,238
Jackson	136,808	162,346	271,592	222,426	903,722	219,823	1,916,717
Saginaw	144,550	124,475	357,801	1,037,897	615,460	230,948	2,511,131
10 Co. Total	15,611,052	5,444,366	14,926,206	18,009,042	49,992,406	31,629,511	135,612,583
Remainder of State	6,222,496	1,399,641	3,518,521	5,329,648	18,599,838	9,079,046	44,149,190
Statewide	21,833,548	6,844,007	18,444,[illegible]	23,338,690	68,592,244	40,708,55[illegible]	79,761,773

Again with the exception of 1988, the indemnity paid for OB claims is less than 10 percent of the total indemnity paid in a given year. The total indemnity paid for OB claims over the 5 1/2 year period being studied accounts for 7 percent of the total indemnity in that period.

Expenses related to these closed claims reflect a similar pattern, constituting 6 percent or less of allocated expenses for all closed claims each year. Allocated expenses for OB claims are consistently lower as a percentage of statewide data than indemnity.

Claims by Medicaid Recipients

There has been a commonly spoken fear among members of the health care community that Medicaid recipients are more likely to sue for medical malpractice, presumably for financial reasons. This fear, combined with the presumption that these individuals may not have sought treatment soon enough and therefore are more likely to have complications, causes doctors and hospitals to be reluctant to accept Medicaid recipients as patients.

Form B attempts to capture data on medical malpractice claims by source of medical expenses payments. The categories for this information are: (1) Medicare; (2) Medicaid; (3) Health Insurance; (4) Other (HMO, PPO, etc.); and, (5) Unknown. The table below is a compilation of closed claim data by medical expense category.

TABLE 10

CLOSED CLAIMS BY SOURCE OF MEDICAL EXPENSE PAYMENT

Year	Medicare	Medicaid	Health Insurance	Other	Unknown
1983	1	0	42	1	1,643
1984	3	1	0	0	1,157
1985	62	121	1	622	1,352
1986	73	111	61	502	1,250
1987	161	233	720	505	1,925
1988	83	120	420	211	1,030
Total	**383**	**586**	**1,244**	**1,841**	**8,357**

Clearly, no conclusions can be drawn from this data given that 67 percent of the forms which contain information in this field indicate that the source of medical expense payments is unknown and that over 5 percent of the closed claim forms did not complete this information.

PART IV

RECOMMENDATIONS

Marketplace

The Insurance Bureau would make no recommendations for changes in the marketplace at this time for several reasons. First, given the long tail for this type of liability, not enough time has passed for the effect of the 1986 tort reforms to be measured.

Further, the availability of medical malpractice insurance is better than it has been in years. Not only are there more options with regard to sources of coverage, but types and amounts of coverage as well. Also, rates are flattening, as insurers are filing fewer and considerably smaller rate increases.

The claim information reported to the Bureau does not point to any specific problem or problems as the cause of the so-called malpractice "crisis," and there is an overall trend of decreasing claim filings against all specialties.

Data Gathering

The information currently being reported to the Bureau is useful, but much could be done to improve the data base. Some of the drawbacks to the existing data stem from the reporting form having been changed several times since the reporting requirements were first instituted in 1976. Unfortunately, there are still changes which need to be made in the form to further refine our ability to evaluate the marketplace for medical malpractice insurance.

The 1986 changes in reporting requirements have further complicated our ability to use the existing data base. The receipt of multiple reports for a single claim has required manual intervention to prevent double counting of data. While the reporting form could be modified to allow for easier identification of duplicate data, the complications of reconciling the duplicate information far outweigh the possible benefits of obtaining it. Further, the only source of information over which the Bureau has enforcement authority is insurers.

Therefore, the Bureau would recommend the elimination of the reporting requirements for sources other than insurers or self-insured entities.

APPENDIX A

MICHIGAN DEPARTMENT OF LICENSING & REGULATION
INSURANCE BUREAU

FORM A
184-200 (6/86)

Code Sheet
Initial Report of Court or Arbitration Action

01-24 Insured's/Plaintiff's Name

25-30 Insured License Number

31-37 Insured Profession and Specialty

38-40 Other Defendants Involved

1 Yes
2 No

Number

FOR OFFICE USE ONLY
Hospital Code

47-49

41-46 Date of Incident. MM, DD, YY.

50-55 Date Complaint Filed in Court or Arbitration. MM, DD, YY.

56-57 Alleged Nature of Complair

58-59 County Code Number

60 Court Identification

1 District
2 Circuit

61-73 Court ID or Arbitration Association Number Assigned to Case.

74-78

NAIC Company Code if known

Company/Attorney Name

Person responsible for this report

Phone

INITIAL REPORT OF COURT OR ARBITRATION ACTION CODE SHEET

Send completed form to: Medical Malpractice Reporting
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909

Insured's Name — Record last name first, space, then first name and middle initial.

Insured's License Number — This is the 5 digit number assigned to the individual by the Department of Licensing and Regulation Health Services Bureau. If hospital, leave blank.

Insured's Profession —

01	Allopathic Physician (MD)	05	Health Maintenance Organization
11	Nurse	03	Professional Corporation
12	Dentist	04	Clinic
13	Podiatrist	15	Other
14	Osteopathic Physician (DO)		
06	Chiropractor		
02	Hospital (only)		

Insured's Specialty — Use the same code that is on the insured policy.

Dates — Record the date the incident occurred and when filed in court or for arbitration.

Alleged Nature of Complaint —

01	Anesthesia Accident	07	Fall	12	Surgery-Unnecessary
02	Blood Transfusion	08	Medication Error	13	Treatment
03	Consent Issues	09	Misdiagnosis	14	Treatment-Unnecessary
04	Delay in Diagnosis	10	Misidentification of Patient	15	Vicarious Liability
05	Delayed/Refused Treatment	11	Surgery-Technique	16	All Other
06	Equipment Failure			17	Obstetrical Procedure

County Code Number — Use list. Refers to county court where case is filed. If arbitration, leave blank.

1. Alcona	29. Gratiot	57. Missaukee
2. Alger	30. Hillsdale	58. Monroe
3. Allegan	31. Houghton	59. Montcalm
4. Alpena	32. Huron	60. Montmorency
5. Antrim	33. Ingham	61. Muskegon
6. Arenac	34. Ionia	62. Newaygo
7. Baraga	35. Iosco	63. Oakland
8. Barry	36. Iron	64. Oceana
9. Bay	37. Isabella	65. Ogemaw
10. Benzie	38. Jackson	66. Ontonagon
11. Berrien	39. Kalamazoo	67. Osceola
12. Branch	40. Kalkaska	68. Oscoda
13. Calhoun	41. Kent	69. Otsego
14. Cass	42. Keweenaw	70. Ottawa
15. Charlevoix	43. Lake	71. Presque Isle
16. Cheboygan	44. Lapeer	72. Roscommon
17. Chippewa	45. Leelanau	73. Saginaw
18. Clare	46. Lenawee	74. St. Clair
19. Clinton	47. Livingston	75. St. Joseph
20. Crawford	48. Luce	76. Sanilac
21. Delta	49. Mackinac	77. Schoolcraft
22. Dickinson	50. Macomb	78. Shiawassee
23. Eaton	51. Manistee	79. Tuscola
24. Emmet	52. Marquette	80. Van Buren
25. Genesee	53. Mason	81. Washtenaw
26. Gladwin	54. Mecosta	82. Wayne
27. Gogebic	55. Menominee	83. Wexford
28. Grand Traverse	56. Midland	

* This form to be completed in compliance with Public Act 173 of 1986. Failure to complete is a violation of Section 438 of Public Act 218 of 1956, the Insurance Code.

INSTRUCTIONS FOR COMPLETING

MICHIGAN CLOSED CLAIM REPORTING FORM
FORM B

Form IBA-210 (8/86)

General Instructions.

Fill in the boxes completely using the appropriate number (i.e., 1 for Yes, 2 for No).

A. IDENTIFICATION

Defendant — Please place the hospital or defendants name and Michigan license number. Individual code numbers will be assigned by the Insurance Bureau to each hospital in the state. Use last name, first name, middle initial. Record whether the insured is the primary or secondary defendant.
Arbitration No. or Court No. & County — This is the number assigned by the Arbitration Association or Court docket number. Record the numbers as requested and in this way the Insurance Bureau will be able to cross-reference Form Bs submitted by different participating organizations for the same claim. County Codes are on the last page of this form.
Claimant's Name — Record last name first, space first name. A further cross-reference for statistical accuracy.

B. COVERAGE

HPL/PHY (Occurence) — Hospital Professional Liability/Physician Professional Liability — Occurence.
HPL/PHY (Claims-Made) — Hospital Professional Liability/Physician Professional Liability — Claims-Made.
HPL Self-Ins. (Occurrence) — Hospital Professional Liability Self-Insurance — Occurence.
HPL Self-Ins. (Claims-Made) — Hospital Professional Liability Self-Insurance — Claims-Made.

C. DATES — **Record by month, day, year.**

Injury — Record the date the injury first occurred.
Filing — Record the date the case was filed in court or arbitration.
Report — Record the date the participating organization first received notice of the injury as a possible claim.
Closure — Record the date the case is finally closed as far as your participating organization is concerned.

D. INJURED PARTY

Age — Enter the claimant's age on date of injury, if the age is months or days so indicate. Enter "UNK" if unknown.
Sex — Check as appropriate.
Type — Patient — any person on the premises for the purpose of receiving medical care.
Other — Any visitor, vendor, employees of contractors, etc.
Medical Expenses Paid By — Check as appropriate.

E. RESOLUTION OF THIS CLAIM

Method of Disposition — Check the appropriate method by which your claim is disposed of. If the claim is abandoned or voluntarily dismissed check "settled by parties."

F. INJURY

This section seeks information on the primary cause, location and severity of the injury to the patient.
Cause — Check the one cause which most nearly matches the primary reason why the claim was brought and/or paid.
Location — Check the one section which most nearly describes where the primary cause of patient's injury occurred.
Severity —
Emotional only — Fright, no physical damage.
Temporary-Insignificant — Lacerations, contusions, minor scars, rash. No delay.
Temporary-Minor — Infections, mis-set fracture, fall in hospital. Recovery delayed.
Temporary-Major — Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
Permanent-Minor — Loss of fingers; loss or damage to organs. Includes nondisabling injuries.
Permanent-Significant — Deafness, loss of limb, loss of eye, loss of one kidney or lung.
Permanent-Major — Paraplegia, blindness, loss of two limbs, brain damage.
Permanent-Grave — Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
Death —

G. **INDEMNITY AND EXPENSE PAYMENTS — Round to Nearest Dollar.**

The first two lines ask for payments made by or on behalf of the organization completing this form. No attempt is made to determine the origin of the payment. Only total expense and indemnity payments are requested.

Allocated Expenses — These expenses include attorney fees, court recorder expenses, copy fees, subpoena fees, etc.

Indemnity — These are indemnity dollars paid to the claimant directly or the cost of a structured settlement. Do not enter the yield of a structured settlement. Record the amount attributable to economic and non-economic damages.

For the Entire Case — Enter the total settlement indemnity paid to claimant, including the indemnity previously reported as paid by or on behalf of this organization. If the total is unknown or the case is not completely settled enter "UNK".

Case Closed Against All Defendants — Check yes or no as appropriate.

Answer Only if Indemnity Was Paid On Behalf Of Hospital — This series of three questions is intended to determine the involvement of the staff physicians, residents and/or interns in cases involving payment on behalf of a hospital. Complete as indicated.

Answer Only If One Or More Codefendants Was Uninsured — This question is intended to determine if uninsured organizations or individuals are participating in claim settlements.

This form is to be completed in compliance with Public Act 173 of 1986. Failure to complete is a violation of Section 438 of Public Act 218 of 1986, the Insurance Code.

Send completed form to:

Medical Malpractice Reporting
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909

LIST OF COUNTIES

1	ALCONA	22	DICKINSON	43	LAKE	64	OCEANA
2	ALGER	23	EATON	44	LAPEER	65	OGEMAW
3	ALLEGAN	24	EMMET	45	LEELANAU	66	ONTONAGON
4	ALPENA	25	GENESEE	46	LENAWEE	67	OSCEOLA
5	ANTRIM	26	GLADWIN	47	LIVINGSTON	68	OSCODA
6	ARENAC	27	GOGEBIC	48	LUCE	69	OTSEGO
7	BARAGA	28	GRAND TRAVERSE	49	MACKINAC	70	OTTAWA
8	BARRY	29	GRATIOT	50	MACOMB	71	PRESQUE ISLE
9	BAY	30	HILLSDALE	51	MANISTEE	72	ROSCOMMON
10	BENIZE	31	HOUGHTON	52	MARQUETTE	73	SAGINAW
11	BERRIEN	32	HURON	53	MASON	74	SANILAC
12	BRANCH	33	INGHAM	54	MECOSTA	75	SCHOOLCRAFT
13	CALHOUN	34	IONIA	55	MENOMINEE	76	SHIAWASSEE
14	CASS	35	IOSCO	56	MIDLAND	77	ST. CLAIR
15	CHARLEVOIX	36	IRON	57	MISSAUKEE	78	ST. JOSEPH
16	CHEBOYGAN	37	ISABELLA	58	MONROE	79	TUSCOLA
17	CHIPPEWA	38	JACKSON	59	MONTCALM	80	VAN BUREN
18	CLARE	39	KALAMAZOO	60	MONTMORENCY	81	WASHTENAW
19	CLINTON	40	KALKASKA	61	MUSKEGON	82	WAYNE
20	CRAWFORD	41	KENT	62	NEWAYGO	83	WEXFORD
21	DELTA	42	KEWEENAW	63	OAKLAND		

01-24 INSURED'S/DEFENDANT'S NAME

31

25-30 LICENSE NUMBER

1. Primary Defendant
2. Secondary Defendant

32-36 COMPANY CODE

37-49 COURT OR ARBITRATION NUMBER

50-51 COUNTY CODE NO.

52-75 PLAINTIFF'S NAME

B. COVERAGE

76

1) HPL/PHY (occurence)
2) HPL/PHY (claims made)
3) HPL Self-insurance (occurrence)
4) HPL Self-insurance (claims made)

C. DATES

77-82 INJURY

83-88 FILING

89-94 REPORT

95-100 CLOSURE

D. INJURED PARTY

101-102 AGE

103 SEX 1 Male 2 Female

104 TYPE 1 Patient 2 Other

105 MEDICAL EXPENSE PAID BY

1) Medicare 2) Medicaid
3) Health Insurance
4) Other 5) Unknown

E. RESOLUTION OF THIS CLAIM

106

1) Settled by mediation
2) Settled by parties
3) Trial verdict
4) Arbitration

F. INJURY

107-108

1) Anesthesia accident
2) Blood transfusion
3) Consent issues
4) Delay in diagnosis
5) Delayed/refused treatment
6) Equipment failure
7) Fall
8) Medication error
9) Misdiagnosis
10) Misidentification of patient
11) Surgery technique
12) Surgery unnecesssary
13) Treatment technique
14) Treatment unnecessary
15) Obstetrical procedure
16) Vicarious liability
17) All other

109-110 ☐☐

1) Critical care unit
2) Emergency room
3) Labor & delivery room
4) Nursery/Peds
5) Operating suite
6) Patient's room
7) Physical therapy dept.
8) Physician's office
9) Radiology
10) Recovery room
11) Special procedure room
12) Other

111-112 ☐☐

1) Emotional only
2) Temp. insignificant
3) Temp. minor
4) Temp. major
5) Perm. minor
6) Perm. significant
7) Perm. major
8) Perm. grave
9) Death

G. INDEMNITY AND EXPENSE PAYMENTS

113-119 ☐☐☐☐☐☐☐ ALLOCATED EXPENSES: PAID BY AND/OR ON BEHALF OF THIS DEFENDANT INCLUDING DEDUCTIBLE, COPAY, EXCESS

120-126 ☐☐☐☐☐☐☐ INDEMNITY: PAID BY AND/OR ON BEHALF OF THIS DEFENDANT INCLUDING DEDUCTIBLE, COPAY, EXCESS

127-133 ☐☐☐☐☐☐☐ AMOUNT ATTRIBUTABLE TO ECONOMIC DAMAGES

134-140 ☐☐☐☐☐☐☐ AMOUNT ATTRIBUTABLE TO NON-ECONOMIC DAMAGES

141-147 ☐☐☐☐☐☐☐ INDEMNITY FOR ENTIRE CASE: PAID BY ALL PARTIES FOR ALL DEFENDANTS IF KNOWN

148 ☐ 1 = YES 2 = NO CASE CLOSED AGAINST ALL DEFENDANTS?

Answer only if indemnity was paid on behalf of hospital
1 = Yes, 2 = No

149 ☐ 1) WAS INDEMNITY PAID ON BEHALF OF THE HOSPITAL PRIMARILY THE RESULT OF ALLEGED NEGLIGENCE OF A PHYSICIAN, RESIDENT, OR INTERN?

150 ☐ IF THE ANSWER TO NO. 1 IS YES, WAS HE/SHE EMPLOYED BY THE HOSPITAL?

151 ☐ IF THE ANSWER TO NO. 1 IS YES, WAS HE/SHE COVERED UNDER THE HOSPITAL'S POLICY?

Answer only if one or more of codefendants was uninsured

152-159 ☐☐☐☐☐☐☐☐ AMOUNT PAID BY UNINSURED CODEFENDANT(S) IF KNOWN?

DATE _____ PERSON RESPONSIBLE FOR REPORT _____ TELEPHONE NUMBER _____

APPENDIX B

APPENDIX B

MEDICAL MALPRACTICE INSURANCE UNDER THE FEDERAL RISK RETENTION ACT

RISK RETENTION GROUPS

Anesthesiologists Professional Assurance Company
c/o Bass, Berry & Sims
First American Center
Nashville, TN 37238

National Dental Mutual Insurance Company,
A Risk Retention Group
44 Montgomery Street, Suite 1400
San Francisco, CA 94104

Ophthalonic Mutual Insurance Company,
A Risk Retention Group
c/o Potomac Insurance Managers, Inc.
Two Wisconsin Circle
Chevy Chase, MD 20815-7003

Osteopathic Mutual Insurance Company
4400 North Lincoln Boulevard
Oklahoma City, OK 73102

Physician National Risk Retention Group, Inc.
8225 Florida Boulevard, PO 46079
Baton Rouge, LA 70895

Podiatry Insurance Company of America,
Risk Retention Group, A Mutual Company
110 Westwood Place, Suite 100
Brentwood, TN 37027

Preferred Physicians Mutual Risk Retention Group
323 West 8th Street
Kansas City, MO 64105

PURCHASING GROUPS	CARRIER
AAPA Professional Liability Risk Purchasing Group 5100 Poplar Avenue, Suite 2100 Memphis, TN 38137	American Continental Insurance Company
The AHA/Health Care Institutions D&O Purchasing Group C/O Gerald Sullivan & Associates, Inc. 800 West Sixth Street Los Angeles, CA 90017	The Doctor's Company

PURCHASING GROUPS	CARRIER
Allied Health Purchasing Group Association 55 East Monroe St., Suite 300 Chicago, IL 60603	Chicago Insurance Co
American Assn of Oral & Maxillofacial Surgeons 9700 West Bryn Mawr Avenue Rosemont, IL 60018	St Paul Fire & Marine Insurance Co
American Dental Purchasing Group 600 Maryland Avenue, SW Washington, D.C. 20024	Frontier Ins Company
American Internists 600 Maryland Avenue, SW Washington, D.C. 20024	Frontier Ins Company
American Part-Time Physicians 600 Maryland Avenue, SW Washington, D.C. 20024	Frontier Ins Company
American Physicians 600 Maryland Avenue, SW Washington, D.C. 20024	Frontier Ins Company
American Health Care Professions Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Transamerica Ins Co
Associations Purchasing Group 55 East Monroe St., Suite 3300 Chicago, IL 60603	Chicago Ins Company
Health Care Center Professional Liability Group, Inc. 8225 Florida Boulevard Baton Rouge, LA 70895	Physicians Natl Risk Retention Group
Health Care Professions Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Transamerica Ins Co
Health Professionals Purchasing Group Capitol Square Building Des Moines, IA 50301	RLI Insurance Co
Healthcare Purchasing Group Association 55 East Monroe St., Suite 3300 Chicago, IL 60603	Chicago Ins Company

PURCHASING GROUPS	CARRIER
Internal Medicine Purchasing Group of America 4 Embaracdero Center, 20th Floor San Francisco, CA 94111-5954	Doctor's Company
MMI Physician Interests 2275 Half Day Road, Suite 320 Bannockburn, IL 60015	American Continental Insurance Company
MI Osteopathic Risk Purchasing Group 33100 Farmington Road Farmington, MI 48024	Osteopathic Mutual Ins Co, Risk Retention Group
National Association of Orthodontists C/O Knapp, Peterson & Clarke Lawyers 70 Universal City Plaza, Suite 400 Universal City, CA 91608	National American Insurance Company
National Dental Liability Plan, Inc 8225 Florida Boulevard Baton Rouge, LA 70895	Physicians National Risk Retention Group
National Dentists Professional Liability Insurance & Safety Group 4931 Douglas Avenue Des Moines, IA 50310	North Atlantic Casualty & Surety Insurance Company
National Indemnity Group, Inc 8225 Florida Boulevard Baton Rouge, LA 70895	Physicians National Risk Retention Group
National Society of Dental Practitioners 1275 K Street, NW, Suite 900 Washington, D.C. 20005	Britamco Underwriters
Nationwide E.M.T. Malpractice Risk Purchasing Group, Inc 2998 Pontchatrain Drive Slidell, LA 70458	Paradigm Ins Co
Nurse-Practitioner Professional Liability Purchasing Group, Inc 151 William Street New York, NY 10038	Insurance Company State of PA
Nurses' Purchasing Group, Inc 4 Executive Park, Suite 2314 Atlanta, GA 30329	Victoria Ins Co Ltd
Nursing Organizations Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Chicago Insurance Co

PURCHASING GROUPS	CARRIER
OUM Group Medical Professional Program 11100 NE 8th Street, Suite 900 Bellevue, WA 98004	Contintental Ins Co
OUM Podiatrist Insurance Purchasing Group 11100 NE 8th Street, Suite 900 Bellevue, WA 98004	Harbor Ins Company
Osteopathic Physicians & Surgeons Professional Liability Association, Inc 1000 Savers Federal Bldg, Capitol & Spring Little Rock, AR 72201	
Osteopathic Physicians & Surgeons Professional Liability Association, Inc 101 University Avenue, Suite 100 Palo Alto, CA 94301	Clarendon National
Professional Nursing Organization Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Transamerica Ins Co
The National Nursing Purchasing Group Association 55 East Monroe Street, Suite 3300 Chicago, IL 60603	Chicago Ins Company
The Nursing Profession Purchasing Group Association 332 South Michigan Avenue Chicago, IL 60604	Chicago Ins Company

APPENDIX C

APPENDIX C

ALLOCATED EXPENSES INDEMNITY & STANDARD DEVIATION BY SEVERITY

Year	Severity	Sum Allocated Expense	Average Allocated Expense	Standard Deviation	Sum Indemnity	Average Indemnity	Standard Deviation
1983	1	467,902	7,930	30,418	274,256	4,648	8,146
	2	153,893	1,948	3,223	274,027	3,468	9,285
	3	2,069,579	4,963	10,914	2,279,702	5,466	9,186
	4	1,253,807	10,362	18,605	1,477,819	12,213	10,187
	5	3,028,181	11,828	36,308	4,850,188	18,946	44,405
	6	2,905,181	15,619	36,633	8,456,243	45,463	353,267
	7	865,526	10,428	20,469	2,168,302	26,124	42,579
	8	2,043,545	34,059	48,729	2,265,412	37,756	93,693
	9	8,950,484	19,758	105,358	14,031,841	30,975	82,289
1984	1	188,352	4,829	4,294	199,350	5,111	7,974
	2	264,780	3,951	3,720	189,032	2,821	7,678
	3	1,559,941	4,967	5,405	1,635,224	5,207	9,345
	4	596,366	6,412	5,506	1,238,892	13,321	19,635
	5	859,832	4,673	4,533	2,097,115	11,397	20,195
	6	783,700	5,892	4,976	2,984,702	22,441	32,665
	7	309,917	7,946	8,311	670,617	17,195	27,109
	8	153,643	6,680	6,085	301,836	13,123	23,032
	9	2,071,934	7,561	8,809	4,624,576	16,878	29,356
1985	1	303,085	4,392	2,767	268,904	3,897	10,514
	2	343,957	3,698	3,288	314,914	3,386	7,094
	3	3,014,616	6,400	15,025	3,355,994	7,125	16,986
	4	2,368,447	15,280	100,365	2,352,253	15,175	26,827
	5	3,149,349	8,266	19,485	6,498,860	17,049	35,380
	6	1,913,860	7,811	7,391	7,666,685	31,292	75,188
	7	1,349,785	9,710	10,110	9,609,773	69,135	109,737
	8	1,158,840	17,558	50,462	7,245,053	109,773	198,170
	9	4,500,620	8,965	9,597	20,142,264	40,124	73,966